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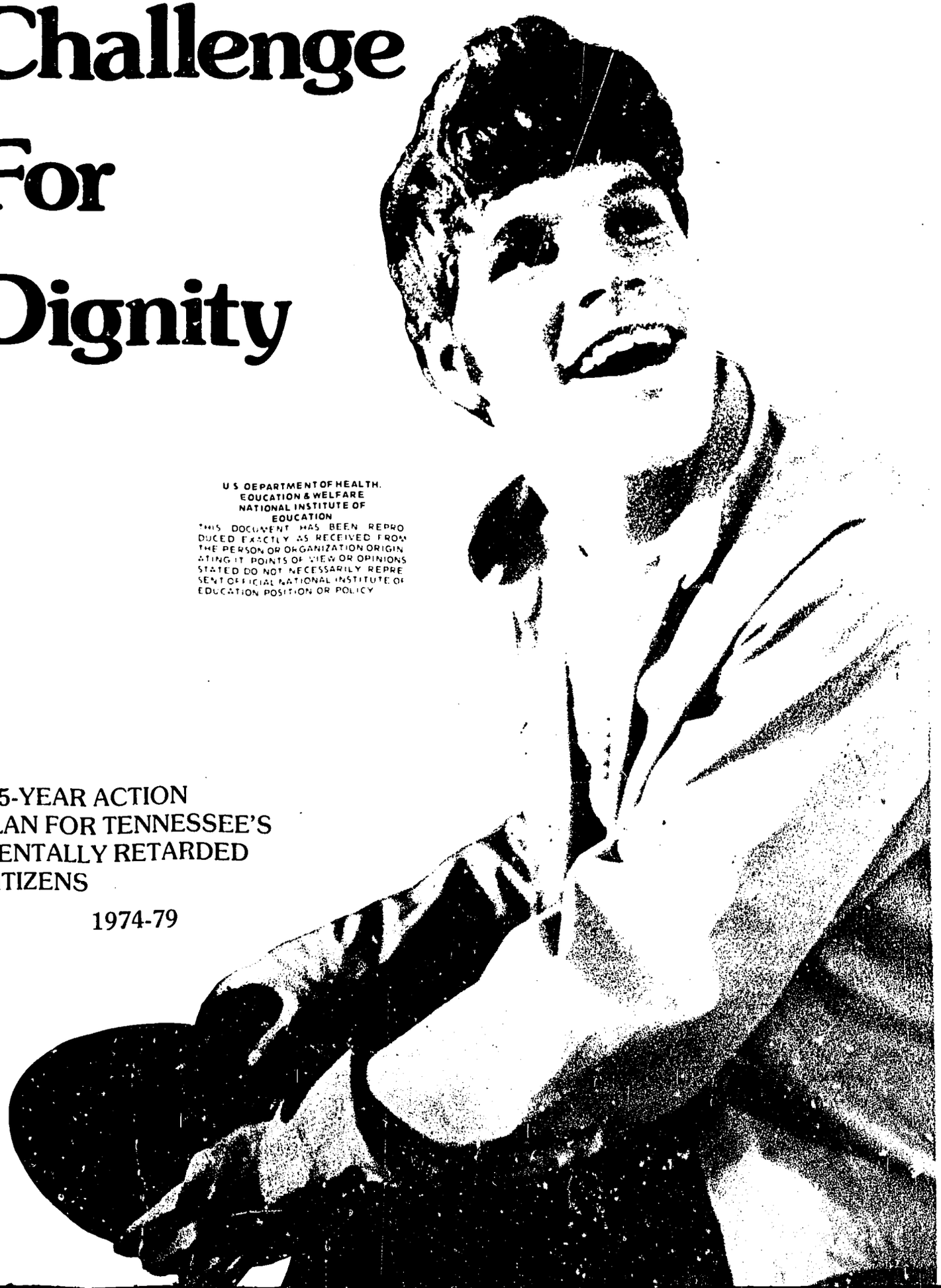
ABSTRACT

Presented is the 5-year (1974-1979) plan of Tennessee by the State Division of Mental Retardation. Changes in philosophy and service delivery to mentally retarded (MR) persons are discussed in terms of definition, causes, classification, and training for employment. Ways of helping MR persons are described in relation to previous efforts and new attitudes such as normalization. Resources for action are seen to include mental institutions as developmental centers which coordinate existing community and school programs in three areas. Strategies for action are proposed for Arlington, Clover Bottom, and Greene Valley developmental centers and for delivery of services to clients through community workshops, residential centers, adult activity centers, and preschool training programs. Maps are provided showing location of residential, adult activity, preschool, and sheltered workshop centers for the three areas and sub-regions (three for each area). Statistical data on costs and client number for the 5-year period accompany the maps. Noted are supportive systems such as research and development. Covered in a plan summary are projections of client growth and costs. (Appendixes include tables, charts, and textual material giving information such as incidence of MR persons and aspects of community programs.) (MC)

Challenge For Dignity



A 5-YEAR ACTION PLAN FOR TENNESSEE'S MENTALLY RETARDED CITIZENS

1974-79

CHALLENGE FOR DIGNITY

A 5-YEAR ACTION

PLAN FOR TENNESSEE'S

MENTALLY RETARDED CITIZENS

1974 - 79

DEPARTMENT OF MENTAL HEALTH

DIVISION OF MENTAL RETARDATION

DRAFT

SEPTEMBER, 1973

PREFACE

"Challenge for Dignity" is a five year delivery service plan of action to meet the ever changing needs of mentally retarded citizens of Tennessee. This action plan has been developed by the staff on all levels of the Division of Mental Retardation of the Tennessee Department of Mental Health.

This action plan is intended to be a flexible document. We solicit reactions from all citizens to assist in keeping this plan updated. This document is our first attempt to present the changing philosophy and approach in offering services to mentally retarded persons, and can serve as a base upon which more detailed plans will be built.

The Tennessee Developmental Disabilities Advisory Council is charged with planning in the broad areas of developmental disabilities, and we are hopeful that this document will be of much value in their planning efforts.

"Challenge for Dignity" belongs to all of us. Each of us has a part in making it possible for mentally retarded citizens to live a life of dignity and have every opportunity to develop to their fullest potential.

Tennessee Department of Mental Health
Division of Mental Retardation
300 Cordell Hull Building
Nashville, Tennessee 37219

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CHAPTER I

THE CHALLENGE OF CHANGE

We are living in a time of rapid evolution with regard to mental retardation programs. Knowledge of the etiology of retardation is rapidly expanding, bringing with it progress in prevention and treatment of retardation. New philosophies are shaping more fruitful approaches to special education, vocational training and residential programs. New community placement options, such as community group homes, are proving their validity as alternatives to institutional placements. In turn, the institutional population is undergoing metamorphosis and evolving toward a greater percentage of younger, more severely handicapped residents. Entire service delivery systems are being drastically redesigned to conform to new ideas regarding the rights and needs of mentally retarded citizens. The traditional institution is becoming a part of a broader continuum of community-oriented services.

Tennessee has kept apace of the sweeping innovations in mental retardation service trends, and in many ways has provided the example for other states to follow. Continued excellence calls for careful planning of new programs and constant, critical reappraisal of current programs. However, a description of the challenge must precede any prescriptive plan. The ultimate goal is that the dignity to which any human being aspires be secured and preserved for human beings who are mentally retarded. The challenge lies in finding the most expeditious methods of guaranteeing that dignity not be denied.

THE DILEMMA OF MENTAL RETARDATION

What is Mental Retardation? Throughout the history of mankind, there have always been individuals who have attracted attention because they were somehow different from the majority of their peers. In some societies, those who were "different" have been treated humanely, and in some cases have even been revered as holy men. In most societies, however, those who deviate from the norm have been ridiculed, mistrusted and shunned. Our society, unfortunately, has traditionally been inconsistent in its treatment of persons whose behavior seemed unpredictable or strange. Most notably, our retarded citizens have not received the full benefits of citizenship.

Most people in our society know little about mental retardation. Even today many of our attitudes are archaic, having carried over from the days when the retarded person was legally defined as an "idiot:"

> . . .it is sufficient to find him so if he has no use of reason, cannot count 20 pence, or to tell his age, or who is his father or mother.
>
> --Old English Law

Most of us have received little or no accurate information about the condition of retardation, and we react to retarded persons out of pity or mistrust, rather than out of experience and understanding. The average citizen probably has a vague realization that the retarded person's problem is somehow "mental" and that he has a low "I.Q.," and there is probably some apprehension that he "cannot tell right from wrong." Most assume that the institution is the proper place for the retarded person, and that he is incapable of benefiting from educational programs or of holding a job. In other words, public misconceptions about retardation are the rule, rather than the exception.

The person who seeks further information is likely to find more misinformation, even in reference books that are supposedly up-to-date. For example, a dictionary of psychological and psychoanalytical terms published in 1958 calls mental retardation merely a "genteelism for mental deficiency," and, in outdated terms, describes several "grades" of mental deficiency, each delimited by a specific range of intelligence quotient (I.Q.) points:

"Grades"	"I.Q. Range"
Borderline Deficiency	70-80
Moronity	50-69
Imbecility	25-49
Idiocy	Below 25

Such a definition epitomizes the view of mental retardation held by the general public until recently. Emphasis was placed upon the concept of intelligence, or lack of it, and mental retardation was treated as a static condition without remedy. Usually no effort was made to differentiate between diagnostic categories, to consider other accompanying conditions, to explain social implications of retardation, or to recommend avenues of remediation. The labels of idiot, moron and imbecile carried a stigma of mistrust and rejection. Such narrow definitions were offered more out of ignorance than malice, because few persons could have legitimately called themselves "expert" in the field of mental retardation until recently.

To a large extent, the public's misunderstanding of mental retardation is the result of confusing it with mental illness. While the same individual may manifest both problems (the mentally retarded may also become emotionally disturbed), in most instances the problems are separate. Briefly, mental illness is a disorder of the personality or the emotions while mental retardation is a condition characterized by subnormal intellectual development.

Mental retardation can be caused by any condition which interferes with a person's intellectual development before, during, or after birth. There is resulting brain dysfunction which will manifest itself during the newborn or early childhood period and for which at present there is no treatment to lift the person to normal intelligence. The mentally ill person may be born with full mental capacities but later becomes emotionally disturbed. Worry, frustration, shock, and other pressures of the present-day world can cause one of the several types of mental illness. Early diagnosis and proper treatment can restore the individuals to normality.

Definitions now reflect the vast gains that have occurred in knowledge regarding the causes and implications of mental retardation. The current standard reference regarding definitions and diagnostic categories in mental retardation is the 1973 revision of the Manual on Terminology and Classification in Mental Retardation, edited by H. J. Grossman, M.D. (American Association on Mental Deficiency, Garamond/Pridemark Press, Baltimore, 1973). The manual defines mental retardation in the following manner:

> Mental Retardation refers to significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior, and manifested during the developmental period.

The definition reflects current professional disillusionment with the use of intelligence tests as the exclusive criterion for determining whether or not a person is retarded. (There are highly intelligent persons who lead notably unsuccessful lives, and persons with relatively low intelligence who succeed admirably.) The definition places equal emphasis upon the way in which a person behaves and the way he thinks. While normal intelligence undoubtedly improves one's chances of successful adaptation to society's demands, it cannot guarantee it. Thus, in order to meet the current criteria

for retardation, a person must begin to display, during his formative years, deficits in both intellectual ability and adaptive behavior.

The current definitions of levels of intellectual functioning are as follows:

Levels of Retardation	I.Q. Range (Stanford-Binet)
Mild	68-52
Moderate	51-36
Severe	35-20
Profound	19 and below

(The previously used term, "Borderline Retardation," has been dropped.)

Levels of adaptive functioning are determined by tables of age-typical behaviors, one of which is reproduced below:

AGE AND LEVEL INDICATED	ILLUSTRATIONS OF HIGHEST LEVEL OF ADAPTIVE BEHAVIOR FUNCTIONING
Age 3 years: SEVERE Age 6 years and above: PROFOUND	Independent Functioning: Attempts finger feeding; "cooperates" with dressing, bathing, and with toilet training; may remove clothing (e.g., socks) but not as act of undressing as for bath or bed. Physical: Stands alone or may walk unsteadily or with help; coordinates eye-hand movements. Communication: One or two words (e.g., Mama, ball) but predominantly vocalization. Social: May respond to others in predictable fashion; communicates needs by gestures and noises or pointing; plays "patty-cake" or plays imitatively with little interaction; or occupies self alone with "toys" few minutes.

Such observational criteria provide landmarks which help the professional worker determine the retarded person's strengths and weaknesses. Such information helps determine the etiology of retardation, provides a "standard" vocabulary for communications between agencies and suggests modes of remediation.

What Causes Retardation? The causes of mental retardation are commonly misunderstood. Many people think that retardation is exclusively a genetic problem, and that the same families continue to produce retarded offspring generation after generation. Only in rare instances is that true. There are

multitudinous causes for mental retardation, many of which are only dimly understood. To put the problem in its proper perspective, it might be useful to draw an analogy between intellectual ability and some physical ability, such as the ability to run.

Most people are born with an "average" ability to run. A small percentage of persons acquire or are born with some physical defect that impairs their ability to run, but the defect is usually due to early illness or accident rather than heredity. Similarly, most persons are born with "average" intellectual ability. Those who are significantly less intelligent than others are usually that way because of illness or accident rather than heredity. Lame children and severely retarded children usually have one striking commonality: they have normal parents.

The Manual on Terminology and Classification lists ten major causes of retardation:

1. Infections and intoxications (Examples are rubella or toxemia of pregnancy.)
2. Trauma or physical agent (Examples are prenatal injury or postnatal injury.)
3. Metabolism or nutrition (Examples are hypoglycemia and phenylketonuria.)
4. Gross Brain Disease (postnatal) (Example: brain tumor.)
5. Unknown Prenatal Influence (Example: hydrocephalus.)
6. Chromosomal Abnormalities (Example: Down's Syndrome, or mongolism.)
7. Gestational Disorders (Example: prematurity.)
8. Psychiatric Disorders (Example: autism.)
9. Environmental Influences (Example: cultural deprivation.)
10. Other Conditions

Is There a "Cure" for Retardation? Brain tissue that is absent or damaged cannot be replaced or repaired. That is not to say, however, that nothing can be done to help the retarded person. Special programs can help a mentally retarded person to achieve his maximum potential and every retarded person must be considered as a developable human being. To continue the previously used analogy between mental ability and running ability, it is clear that a person who has good coaching and who practices earnestly can learn to run better. On the other hand, lack of exercise gradually diminishes a person's ability to run. Much the same principle applies to intellectual ability: good teaching and constant practice will improve intellectual functioning, while lack of stimulation and activity will most probably cause its decline.

Who Are the Mentally Retarded? Mentally retarded citizens come from all walks of life, all age groups, all races. They are spread evenly throughout the population. Thus, wherever the population is heavily concentrated, there are greater numbers of retarded individuals, while in rural areas the numbers are fewer.

More severely retarded children are recognized during infancy, but less impaired children are often not identified as retarded until they begin to fail in school. (The percentage of persons identified as "retarded" rises during the school years and drops afterwards. Although many mildly retarded people have trouble with intellectual tasks in school, they adjust well later on in occupational settings and no longer meet the criteria for retardation.)

Since most retarded people enjoy a relatively normal life expectancy, there are many more retarded adults than retarded children.

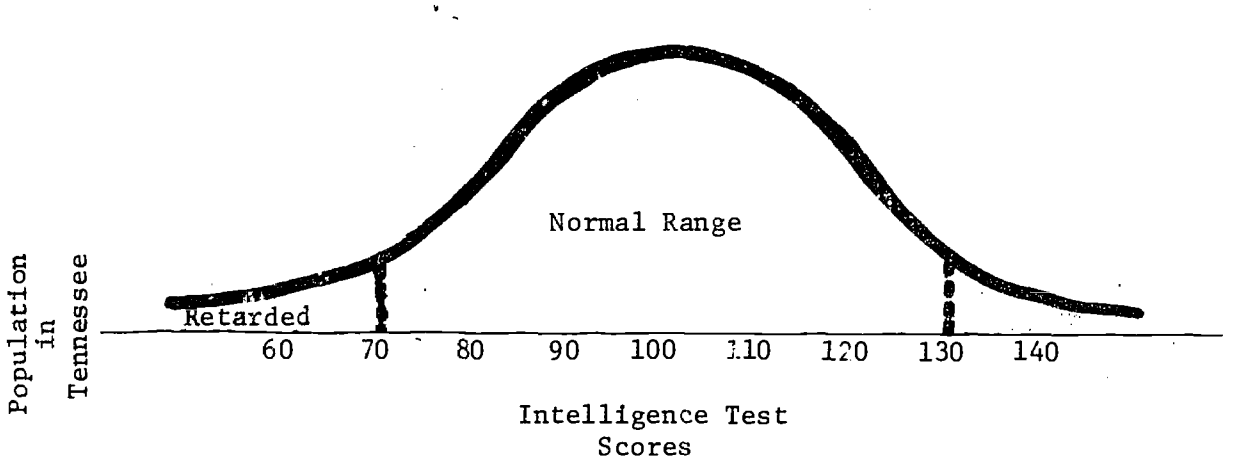
The retarded persons in our state institutions number around 2,700 or less than three percent of the mentally retarded population of Tennessee. Most mentally retarded persons live in the community. Younger or more severely impaired persons usually live with parents or guardians. Many

mentally retarded persons even live relatively independent lives needing assistance only during times of crisis. Of the citizens residing around you, approximately one in forty is retarded.

How Many Retarded Persons Are There? Silverstein (in the AAMD Journal, January, 1973) makes the important point that, depending upon one's criteria for retardation, estimates of the number of retarded persons in the United States may vary from a mere 100,000 persons to over 30 million persons! Common sense dictates a conservative approach to estimating the prevalence of retardation, limiting the definition to include only those whose intelligence and adaptive behavior are significantly impaired, and who are likely to require specialized assistance at some time in their lives.

The popular rule of thumb for estimating the incidence of significant retardation among the general population is three percent. (Such a rule is probably relatively accurate for the newborn population, but since chances of premature death increase with degree of retardation, the percentage among the living population may be less than 3%.) Therefore in Tennessee, based upon a population of 4,000,000, there may be 120,000 persons who exhibit poor adaptive behavior and whose I.Q.'s fall below 70. Appendix I shows statistical estimates based on the three percent incidence rate and calculated on a county-by-county basis.

What is Abnormal Intelligence? To get an idea of what is meant by "abnormal" with regard to intellectual functioning, imagine that we know the I.Q. of every person in Tennessee and can construct a graph showing how many people fall into each scoring category. The graph would look something like the one below:



The scores would form a bell-shaped curve with the vast majority of citizens (over 95%) falling into the middle between 70 and 130. The most common score would be 100 or "average." While people who scored above 130 would be "abnormal," in a sense, it would be a very desirable sort of abnormality: exceptionally high intelligence. It is the citizen whose score falls below 70 who is considered abnormal or exceptional in the negative sense. He is the individual who may find difficulty in meeting the everyday demands of our society.

The concept of "adaptive behavior" is much the same, but depends upon practical functions such as money handling, cooking, dressing, personal cleanliness, and so forth, rather than purely intellectual tasks as criteria.

Special educators work with physically, emotionally and intellectually handicapped children in either special settings or regular classrooms in the public schools. Such special assistance will help many of Tennessee's mildly retarded children "escape" from their diagnostic category into the normal range of the "average" citizen.

What Can a Retarded Person Do? He can do a lot more than most people think he can. For example, given the proper training and assistance, a person with an I.Q. of 60 may live a relatively normal life in the community enjoying a rich variety of educational, social, vocational, religious and leisure activities. Even the most severely

retarded persons, given the proper conditions, may engage in self-fulfilling and productive activities. By helping the retarded person become more independent, society reaps many benefits. The person who at one time was doomed to occupy a hospital bed for his entire life is today being helped to become a productive member of the community. Rather than existing as a continual burden, he can help himself and others.

The variety of types of productive employment for which retarded persons can be trained and meet success is long. Examples of vocational possibilities might include elevator operator, housekeeper, food service worker, cook, clerk, maintenance worker, vehicle maintenance helper, stock clerk, photocopy operator, painter, and the list could continue at length. The promise of productivity and happiness, rather than dependence and inactivity, is reason enough to plan new programs for Tennessee's retarded citizens.

HELPING THE MENTALLY RETARDED: A CHANGING PHILOSOPHY

Services provided to mentally retarded persons and the overall quality of their entire way of life are shaped in accordance with a philosophy undergirding society's entire frame of reference when considering persons who might be rather different or somehow inferior to "normal."

Early Views and Efforts: There were some surprisingly early efforts to establish humane facilities and programs for retarded persons in this country. The nation's first experimental school for mentally retarded children, the Perkins Institute, was established in Boston in 1828. In the 1850's and 60's the states of New York, Ohio, Connecticut, Kentucky and Illinois established institutions for the retarded. Elwyn Training School, the country's first private school for mentally retarded children, was founded in 1852 in Pennsylvania. The American Association on Mental Deficiency was founded in 1876, and special education classes in some large public school systems were begun between 1896 and 1902 in Rhode Island, Illinois, New York, Pennsylvania and California.

Unfortunately, such efforts were scattered and few. In most areas, mentally retarded persons were thought to be hopelessly untrainable and were viewed with mistrust and fear. Despite good intentions, programs for mentlly retarded persons usually served the primary purpose of "relieving" the public of its "burden" rather than providing for the benefit of those who were retarded. Some mentally retarded persons spent their lives in prisons, deprived of all rights, simply because there was nowhere else for them to be housed and society felt their removal necessary. After the advent of mental institutions, mentally retarded persons were frequently placed in such institutions, lumped with and receiving the same treatment as the mentally ill residents. Such mental institutions, in their early

stages of development, afforded little more than custodial care. Later, institutions for mentally retarded citizens began to crop up in some states, usually founded with the idyllic, but short-lived, goal of keeping the mentally retarded person happy, content and out of harm's way.

In Tennessee, it was not until 1923, that an institution specifically intended for the care of mentally retarded persons was constructed. Although originally conceived as a rehabilitation center, Clover Bottom Home soon became overcrowded with persons needing care and forgotten by the society that welcomed the home's existence yet often refused to afford the resident basic conditions necessary for decency.

Following the prevalent philosophy concerning mental retardation in that era, institutional care seemed the only feasible solution to the need for housing and caring for mentally retarded persons. The institutional model was appealing in the sense that it was economically efficient and it kept the retarded residents "out of sight, out of mind." Society and government could relax, secure in the knowledge that "everything possible" was being done for mentally retarded residents.

New Attitudes: Gradually attitudes toward mentally retarded persons have changed. In the early decades of this century studies began to discredit the beliefs that mentally retarded persons were responsible for a large proportion of crimes in this country, that all retardation was inherited, that retarded persons were unable to benefit from education, and so forth. Mistrust gave way to an attitude of paternalism, and efforts were made to create institutional services to "protect" mentally retarded persons. While institutional care was certainly more humane than had been prior approaches to treatment, the result still netted a deprivation of personal rights and liberty for many institutionalized persons.

Many persons labeled "mentally deficient" made valuable contributions in military service and the war industries during World War II which also

helped dispel some public misunderstandings. Parents of mentally retarded children also contributed much to the effort of developing new attitudes by organizing and exerting pressure on legislative bodies and educational, medical and social service agencies. The National Association of Parents and Friends of Mentally Retarded Children was established in 1950. Today, known as the National Association for Retarded Children, the organization has a membership of approximately 250,000 people, as subdivided into 50 state organizations (Tennessee's membership numbers over 6,000) and has become a strong influence in promoting improved facilities and services for retarded persons.

A number of other factors have converged to create a change of climate in the field of mental retardation. In the 1960's broad research programs were begun in the U.S. and several other nations notably Russia, England and Sweden. (One of the largest and best-known research centers is located in Nashville, Tennessee at the George Peabody College for Teachers.) Research and professional training were especially stimulated by the influence of the Joseph P. Kennedy Foundation and the personal efforts of the late President John F. Kennedy.

NARC, AAMD and other agencies devoted to the improvement of services for the handicapped have made significant strides in promoting legislation and fostering service development to help mentally retarded persons enjoy their rights as citizens, obtain adequate care, and participate in educational and vocational programs. The plight of the retarded person has received publicity from time to time in the news media. Many colleges and universities have initiated programs to teach students the facts of mental retardation and the methodology for dealing with it.

Today there is a new public awareness of mental retardation and its ramifications. The problem has lost much of its stigma and has become a legitimate topic of concern for medical, social, political, vocational,

legal and educational experts. Perhaps this change in philosophy concerning mental retardation can best be described through the brief explanation of two concepts: "normalization" and human rights.

The awareness of the dilemma of mental retardation has fostered an acceptance that mentally retarded persons are human beings and, as such, should possess the same rights and dignities offered any other person. The human approach recognizes the fact that every mentally retarded person, regardless of the severity of his handicap, has a potential for development and should be offered the opportunity to reach that potential.

Equally as important as the recognition of mentally retarded persons as developable human beings is the adoption of the concept of "normalization" as a criterion for judging the suitability and adequacy of programs. The goal is the achievement of a state that is as "normal" or near normal as possible. Life on an institutional ward is not "normal." Life at home with parents for a 30 year old male is not "normal." Sharing an apartment with a peer is more normal for a young adult. Attending the same school, church and movie theater that a child's brothers and sisters attend is "normal." The achievement of normalization may not always be feasible or in the client's best interests in some individual cases, but any denial of normalcy should be justified only on the grounds of specific limitation due to handicaps. The least restrictive alternative should always be chosen, thus allowing each mentally retarded person the broadest exercise of his human rights and privileges that his handicaps permit.

The 87th General Assembly of Tennessee passed a resolution that set forth the rights of mentally retarded persons and was patterned after the "Declaration of General and Special Rights of the Mentally Retarded" adopted by the International League of Societies for the Mentally Handicapped.

If the tenets of this declaration are followed, the mentally retarded persons of Tennessee will be enabled to assume their rightful place. (See Appendix II)


Resources For Action

CHAPTER II

RESOURCES FOR ACTION

Mental Retardation is a condition characterized by a multiplicity of problems that interact to produce an individual with a capacity for functioning in everyday life situations that is substantially reduced from that of the "normal" human being. Because of the complexity of the condition, no single purpose agency or program can purport to adequately meet all the needs of any individual who is mentally retarded. In fact, all agencies, organizations or even individuals offering human services should strive not to exclude the mentally retarded person because of his handicap. All too often, the frame of reference in considering any type of handicapped person has been to consider him as primarily handicapped and provide a special service or situation to accommodate his needs. A reversal of this approach emphasizes that mentally retarded persons are more like than unlike any other person and any handicaps associated with mental retardation are secondary to their rights and privileges as human beings. This "human" approach mandates a searching reappraisal of the responsibilities of every organization concerned in some way with the well-being of Tennesseans. Traditionally, it was considered to be the mandate of the Department of Mental Health, Division of Mental Retardation, to provide for the care and training of the mentally retarded. Lines are no longer as clear-cut and a redefinition of function and readjustment of traditional spheres of action are on the forefront if we are to achieve true citizenship for mentally retarded Tennesseans.

Turn-of-the-century idealogies concerning human services dictated that cities and local communities care for their own. This "charity begins at home" concept became eroded as the needs for services outstripped the availability of local resources to meet demands. The depression of the 1930's marked the entry of the national government into the human services area. The pendulum now has begun to swing back to the communities as possessing a better potential capacity for concerned and enlightened action for its own citizens with specialized needs than the perception of the state or national government can allow.

The Sharing of Responsibilities. The Division of Mental Retardation is concerned with the quality of life of every developmentally disabled citizen of Tennessee. What are the implications of this concern; what has been the approach prior to the changing philosophy; and how does the Department of Mental Health now perceive its role in the total framework of service delivery?

In the past, the need for care and training of mentally retarded persons was answered through institutionalization. Clover Bottom Home for the Feebleminded in Donelson was opened in 1923 to provide care in a pastoral setting for "imbeciles." Greene Valley Hospital and School opened its doors in late 1960 and the institution at Arlington received its first residents in 1969.

By the nineteen sixties, it had become apparent that institutional construction could not keep pace with demand and that the institution was an expensive and often inappropriate medium for meeting the needs of most mentally retarded persons. The Department of Mental Health was serving only about 2,500 mentally retarded persons, of an estimated mentally retarded population of 120,000. Waiting lists grew long; many parents were unable to secure training for their children who could not be admitted to

the institution; the institutions fell under criticism for the quality of care and training offered residents; legislators were appalled at the cost of quality institutional services and the entire system became ripe for change. This state of affairs was not unique to Tennessee. It was happening across the nation.

Parent groups, some professionals, and advocates for the mentally retarded attempted to impress upon the general population the idea that mentally retarded persons are human beings too, that they are also citizens of the United States and as such should be entitled to the same rights, privileges, and dignities of any other citizen, such rights encompassing the opportunity to live as normal a life as possible. Favorable response to the idea grew until finally the national government, state government, local government and interest groups of all types began to accept the idea of "normalization" and community training for the mentally retarded.

Tennessee began moving toward community services in the late 1960's and the idea grew quickly. Community based programs were established primarily for day training of children and adults. Federal funds helped boost the idea. At present, the Department of Mental Health, Division of Mental Retardation, participates in funding over 80 separate and distinct community programs, offering day training for children and adults, vocational training and several pilot types of residential programs. The drive toward community involvement in meeting the needs of the developmentally disabled is still in the early stages. The needs are far from being met, but the accomplishments to date support the movement toward community development and provision of services by and in local communities.

This change in approach recasts the traditional responsibilities of all agencies and organizations involved in delivery of human services, and dictates that each agency scrutinize its purpose and activities with respect to including the mentally retarded. The Department of Mental

Health must become the leader in realigning its approach. Traditionally providing an omnibus type institutional program designed to offer the full array of services to meet an endless variety of needs of mentally retarded persons, the Division of Mental Retardation must readjust traditional patterns of service and assume a new role. First, the Division must set an example by becoming a major coordinator of all types of services to the mentally retarded provided from a variety of sources, both private and public. The Division must become a primary advocate of the normalization principle and take all necessary steps to assure that mentally retarded persons become integrated into the mainstream of society. The Division must impart to the general public the message concerning mental retardation and seek to assure that human rights and dignities are not denied mentally retarded persons merely on the basis of their handicaps. The Division must assume the role of innovator as well as assistant in the provision of the complete array of programs required to assure every mentally retarded person the proper services suited to his need at the appropriate time.

The Division must provide highly specialized programming for mentally retarded individuals whose needs cannot be appropriately or adequately met by any other means. An example of specialized programs might be the mentally retarded child with bizarre behavior problems. The overlay of complicated treatment and training needs results in the individual "falling-between-the-cracks" or being ineligible for any single purpose program offered by any other agency. The Division must continue to upgrade the quality of training and care offered persons with handicaps of such degree that participation in institutional life is required. With this role concept in mind the Division has adopted the following set of long range goals to serve as a guide to all efforts as well as a rule for the measurement of

all achievements.

1. Development of a coordinated system for delivery of comprehensive community services to meet the needs of mentally retarded persons regardless of age or severity of handicaps. Such services include counseling and social services, diagnostic and evaluation services, day training for children and adults, vocational training and work, sheltered employment, and a broad array of community residential programs and services.

2. Decentralization of the existing institutions for the mentally retarded, primarily through the provision of community services, which would include movement of institution residents back to the community, and development of community alternatives to prevent institutional admission.

3. Upgrading of institutional care and training services to offer the highest quality of life for those mentally retarded persons whose needs require institutional placement and to prepare other residents for successful community placement.

4. Achieve full accreditation by AC/FMR of each institution and community facility that serves the mentally retarded.

5. To protect and assure the legal and human rights of the developmentally disabled, which include the right of care and training and the right to live as normal a life as possible.

6. Development of professional and para-professional staff capability for the provision of a full array of technical assistance in the design, implementation and operation of service programs as well as for the delivery of a high quality of services to mentally retarded persons involved in community and institutional programs.

7. To achieve acceptance of and normalization for mentally retarded citizens and to influence local communities to accept responsibility for developing programs to serve the citizens of the community.

8. To support active research programs that have promise in the prevention of mental retardation.

The achievement of these goals will require the energies and abilities of all agencies and concerned individuals from both the public and private sector.

The Department of Education has been involved with the provision of educational services to mentally retarded children eligible for special education classes. EMR (Educable Mentally Retarded) and TMR (Trainable Mentally Retarded) classes in operation across the state are currently serving over 16,450 children. However, many low-functioning mentally

retarded children have been excluded from EMR and TMR classes. These were often the children without the necessary self-help skills (feeding, toileting) for relative independence in the classroom situation, or the mentally retarded children with other handicapping conditions or behavior problems that presented disruption to an orderly schoolroom routine. The result has been that children who were in the most dire need of services were often those who were first denied the educational or training opportunities of the local school system. The Education of the Handicapped Act (Chapter 839, Public Acts of 1972) assigns the Department of Education and the local school systems of the state the full responsibility for the training of all handicapped children ages four through twenty-one years. Scheduled for full implementation by the fall school term of 1974, the Act is one of the most progressive and far-reaching mandatory education laws in the nation. The implications are exciting, for the "mainstreaming" effect for handicapped children's intergration into the institution of education is the epitome of the normalization theory. Normal children have a right to public education. The Education of the Handicapped Act extends that right to all children and is also a formal recognition of the theory that reaffirms all handicapped children should be taught. One major effect of the Act is the assignment of some training functions, especially those concerning very low functioning children from the Department of Mental Health (often in cooperation with the Department of Public Welfare) to the Department of Education. The impact in many areas, such as accredited schools located on the grounds of the Developmental Centers, has yet to be fully analyzed. Waiting lists for services of the Developmental Centers should assume a more realistic perspective as parents in need of basically the services provided by the new Education of the Handicapped Act begin to approach their local boards of education for the services they formerly expected through the often unwanted alternative of

institutionalization.

Many hours of discussion and dialogue among all parties affected by the new legislation are expected and anticipated before commitments and responsibilities can be finally delineated. And again, in all probability, the lines that are drawn will necessarily be flexible in order that the handicapped child meets no closed doors to needed services.

The Division of Vocational Rehabilitation of the Department of Education provides opportunities for vocational training for mentally retarded persons who have a potential to become successful in competitive employment situations. The current good working relationship with the Division must be reinforced. The Division of Vocational Rehabilitation also has expertise to lend in the structuring of programs for mentally retarded persons with potentials which fall short of competitive employment and are good candidates for sheltered workshop programs provided under the auspices of the Department of Mental Health.

Many mentally retarded persons, especially adults, meet the criteria for eligibility for categorical assistance through the Department of Public Welfare. State and community programs have been able to enlist the cooperation and commitment of the Department of Public Welfare in efforts to meet both training and residential needs of many adults. Foster care for mentally retarded children is another joint venture of the two departments that should be expanded.

Input has been minimal from the Division of Mental Retardation to state single purpose planning and coordinating agencies concerned with programs and services that should involve mentally retarded persons. Relationships must be strengthened with agencies such as the Commission on Children and Youth, and the Interdepartmental Committee for Child Development to assure their realization of the principles of normalization and to seek affirmative ways the agencies can support the efforts of

each other.

The Department of Public Health is involved with programs which have significant implications for mentally retarded persons. Intermediate Care Funds, administered through the Department of Public Health currently assist in the support of over 1,823 residents of the Developmental Centers. Additionally, the use of ICF for the purchase of skilled nursing care in community based facilities, both public and private, is anticipated as becoming an important resource and a strategy that would release the resources of the Developmental Centers into other avenues of specialization. The involvement of the Department of Public Health in maternal and child health programming, especially in deprived socio-economic regions of the state, has an indirect impact on mental retardation programming that cannot go unapplauded. Some of the major causes of mental retardation can be traced to the effects of poor prenatal, perinatal and postnatal care of mothers and infants. Phenylketonuria screening, performed by the Department of Public Health, promises to almost eradicate the incidence of PKU in Tennessee in the future. The intensive efforts of the Department of Public Health have served to reduce the number of cases of mental retardation caused by rubella (measles) in pregnant women. Prevention of mental retardation cannot be the lone crusade of only one agency or organization but will require the cooperative efforts of all concerned. Avenues must be explored to further cooperation between the Department of Mental Health and the Department of Public Health in the areas of prevention as well as treatment of conditions associated with mental retardation. The treatment of acute dental problems of many multiply-handicapped, mentally retarded persons is only one formerly neglected area open for action.

Private, non-profit enterprise has already joined forces with state and federal governments to provide needed services for mentally retarded citizens in or near their home communities. Private, profit-making enterprise

has now entered the competitive market for services to the handicapped and has sought to find ways to provide a quality service, at a reasonable cost, and continue to retain a reasonable profit. The use of properly regulated, private enterprise for the purchase of specific services offers an opportunity for rapid expansion in the number of clients receiving services by or through the auspices of the State of Tennessee. Private enterprise is unencumbered by the "red tape" of government. Mechanisms for efficient and effective utilization of this resource, guaranteeing a high quality of service under proper procedures of control, must be forthcoming if Tennessee is to be prepared to react when approached by private, for-profit concerns.

Grass Roots Support. The challenge to the cities and communities of Tennessee to provide the full array of services needed by their mentally retarded citizens has been received with mixed emotions by parents, community leaders, informed citizens and the general public. In some instances, intent to establish a group home in a small community has instilled a fear in neighbors either for their personal safety or protection of their real estate values. Neither fear is founded in truth, yet a lack of proper, public information or education has yielded the community program two strikes against it before it opened its doors. The Department must assume a more active role in public information and public relations, educating the citizens to the dilemma of mental retardation as well as to the responsibility of the local community to provide the appropriate opportunities for handicapped citizens.

In addition to intensified efforts toward public information, the Department of Mental Health must respond to the communities' needs and interests in developing mental retardation programs with expedient administrative support for the entire community services effort. Red

tape, lack of concise ground rules, unexplainable delays and other administrative and organizational restrictions must be overcome, with built-in accountability for the actions of all parties involved.

Not only must the Department plan for optimal administrative effectiveness, the communities must also streamline administrative mechanisms to assure efficient and effective utilization of all resources. An umbrella type agency, operating several separate services for the mentally retarded in a given community would be one illustration of community cooperation to avoid duplication as well as fill gaps in service. Improved coordination among related services, conservation of costs through the pooling of administrative staff, ease in contracting with the state for services for mentally retarded citizens and increased visibility to the general public could be only a few of the positive effects of community organization. Another alternative for effective community organization might be the creation of satellite programs of urban centers to enable specialized services to reach outlying areas. The possibility of similar services within a given area pooling their resources and talents and organizing for the exchange of information and ideas is another alternative worthy of exploration.

Organizing for the Delivery of Services - The Division of Mental Retardation

Development of community programs to serve mentally retarded individuals and decentralization of the traditional institution are integral parts of the same movement - provision of a more normalized environment and more adequate training possibilities - and cannot be arbitrarily separated. The institutions are a repository of professional and technical expertise. They are visible to the general public as a service center to meet the needs of mentally retarded citizens. They possess the administrative mechanisms for management of people and funds. In addition, they house a substantial number of the target population for community programs. The institutions cannot

successfully be bypassed in plans aimed at achieving the goal of the provision of the full array of services to mentally retarded citizens offered in the local community.

The development of most existing community programs was begun by a few diligent members of the central office staff of the Division of Mental Retardation with the aid of some institutionally based personnel. Progress was rapid and the task quickly outgrew its master. By mid-1973, the Division was participating in over eighty separate and distinct community programs. Each program functioned as a separate entity under grant or contract provisions through the State and/or Federal government, with local participation. Most community programs had been initiated through the development of private, non-profit corporations, each creating and operating its individual program.

The need for personnel assigned to duties in conjunction with community based services was answered with a reassessment of the organizational system and a plan was created to effect and facilitate the new approach. For the purpose of delivering community services, the three Hospital Service Areas have been redefined as the East Tennessee Developmental Center Service Area, Middle Tennessee Developmental Center Service Area, and the West Tennessee Developmental Center Service Area. All services for mentally retarded people in each area will be coordinated through the Developmental Center located therein. The Superintendent of the Developmental Center is ultimately responsible for community development in the service area. He is vested with the responsibility to coordinate all resources of both the institution and the community to meet the needs of the developmentally disabled.

An Assistant Superintendent for Community Services is assigned direct responsibility for community service delivery and development in the service area. In addition to supervisory responsibility over the regional community service staff, he is responsible for the institutional day training center,

adult activity center, any community residential facilities located off the grounds but administratively attached to the institution, respite care services, after care services and diagnostic and evaluation services for the service area.

As the number of types of community based programs in each region increases, the necessity for decentralizing the community service staff can be foreseen. In anticipation of this development, each service area has been further divided into three developmental regions (such developmental regions correspond with the nine planning regions created by the State Planning Commission). Eventually, each developmental region will require a component community service staff stationed in the field and responsible to the Assistant Superintendent for Community Services at the institution. In addition, services offered by each major metropolitan area of the state may eventually justify the creation of as many as four additional regions. (See Appendix III.)

A Regional Director of Community Services will directly supervise the community services staff assigned to each developmental region. Although responsible to the Assistant Superintendent for Community Services, it is intended that the Regional Director be free of institutional responsibilities and enabled to concentrate his attention and direction on community services.

The regional community services team is currently comprised of a curriculum specialist, social service specialist and a community development specialist. Eventually, it is planned that representatives of all disciplines needed for technical assistance, planning, guidance and coordination be available for assistance to community programs through the regional office.

Eventually, it is anticipated that a complete restructuring of the administration of services to mentally retarded persons and redefinition of the proper role of the institutions will evolve. The day should come when the existing institutions will be one service in the broad array of services available to mentally retarded citizens.

The "Developmental Center" Concept

The new model of services to be set into motion by this five year plan requires a drastic change in the use of institutions. The omnibus type institutional program is expensive, is inappropriate for many residents, and is a contradiction to the normalization principle for a large number of residents who could and should function in a less restrictive environment.

Reactions nationwide to the institutional pattern of service delivery have often pitted the extremists of both sides against each other: one advocating the complete demise of all institutions, the opposition defending the institution with arguments cloaked in the "protective" attitude. Balancing the viewpoints of both the extremists concerning the fate of institutions, Tennessee has developed a plan whereby the institution can become not only an integral part of the change to a new system, but the actual focal point around which change is centered. (Note the discussion on Organizing for the Delivery of Services.)

Clover Bottom, Greene Valley and Arlington Hospitals and Schools were redesignated as Developmental Centers by the 88th General Assembly. The title connotes the type of resource to the developmentally disabled that each of the three desires to evolve toward through planned strategies for change. Two broad goals for the Developmental Centers have guided the planning and discussion concerning the future of Tennessee's institutions.

1. Development of a highly specialized programming, technical assistance and leadership cpacity for both on-grounds programming and for support and guidance of services delivered in the community.

2. Achievement of full accreditation by the Accreditation Council for Facilities for the Mentally Retarded of the Joint Commission on Accreditation of Hospitals.

The term specialization is a key word in the developmental center plan. The new JCAH standards for accreditation of residential facilities and proposed guidelines of the Department of Health, Education & Welfare which parallel these standards could, if invoked, control access to ICF and other Title XIX payments for care. Compliance with these standards, which are very high, will require large investments of financial and manpower resources. It will be very difficult to afford an accredited institution offering an omnibus type program. If the facility intends to serve mentally retarded residents of all ages, all degrees of physical and mental handicaps, all types of psychological and behavior handicaps, and varying degrees of sensory problems, large sums of money will be required for each of these program areas to achieve accreditation. The answer is specialization of on-grounds programming to serve only those mentally retarded persons whose handicaps are of a nature that community services are inappropriate.

Another reason for restructuring the institutional model is the need for coordination of community based programs, the technical and professional programming assistance that must be supplied to the community, and the provision of sophisticated specialized services of the highest quality that the community could not justify or support.

A brief description of the "developmental center" concept will set the stage for the reiteration of strategies for institutional change.

On-grounds training and treatment services offered by a developmental center should evolve toward provision of highly specialized, intensive training programs supported by necessary professional expertise in all disciplines

required, such as occupational therapy, physical therapy, speech therapy, audiology, behavior modification, psychology, education and so forth. The residential population of a developmental center should consist primarily of low functioning, severely and profoundly mentally retarded persons, often with associated disabilities, for whom highly specialized treatment or training is needed in the developmental center environment. Most mildly, moderately and many severely and profoundly mentally retarded persons belong more appropriately in community based facilities. On-grounds specialized programming should fully meet all accepted accreditation standards for excellence in the quality of services provided.

Developmental Centers should be responsible for the provision of assistance, support, as well as, guidance to all types of community based programs for the developmentally disabled. This assistance might be provided through making available highly skilled professional counseling and guidance in specific program areas such as physical therapy or curriculum design. Specialized teams could be developed to provide some types of services the community programs could not afford or justify. Examples are speech therapy and psychological counseling.

Developmental Centers should become a valuable resource to parents or interested citizens. Communities will require assistance in locating appropriate resources to meet habilitative needs of clients. High quality diagnostic and evaluation services, if coordinated and made a key link in the total delivery system, could be one of the major supporting factors in the success or failure of the new approach to services (see page 53). Diagnostic and evaluation services should be of a quality and degree to eventually support research into the causes or manifestations of mental retardation. Diagnostic and evaluation services must be of a high quality

to adequately guide the selection of the best placement for a mentally retarded client in the most appropriate alternative.

Through the provision of programs for parental guidance, family training and other types of family supportive services (including respite care services), the Developmental Center can play a primary role in the overall success of alternatives to institutionalization.

Training of personnel for both on-grounds programming as well as community programming is another service that a developmental center should be in the most advantageous position to provide. Developmental centers will house highly trained professional staff (required by accreditation) whose energies could also be utilized in the area of training coordination, conduction of special seminars and conferences and provision of training opportunities for personnel involved in community programs.

As an illustration of the concept of inservice training offered to the community, a program might be established whereby the retarded individuals who will enter a new community program, as well as the employees of that program, might be brought into the developmental center for a short period of intensive training before the community program commences operation. Such a training period would enable the staff to receive intensive professional training, and a complete diagnosis and evaluation of the residents of the program could be performed.

Developmental Centers should be able to eventually provide the expertise to develop teaching materials, methods, films, and other resources for community programs, utilizing the results of research and pilot programs as well as the collective thinking and ideals of topnotch professional personnel.

The points outlined above are merely illustrations of the "developmental center" concept and the itemization of purposes and uses of the developmental center in the total delivery system is open to further elaboration. It is

planned that through the transformation of the institution into a true resource center for mentally retarded individuals and the inclusion of the facility as an integral part of the community delivery system, Tennessee can best utilize existing resources and mold their usage to more expeditiously meet stated goals.

Strategies For Action

CHAPTER III

STRATEGIES FOR ACTION

The Division of Mental Retardation's guiding philosophy for serving mentally retarded persons steadily emphasizes normalization of life experiences and recognizes the individual's right to a life with dignity. To reach the Division's goal of providing adequate and appropriate services to mentally retarded citizens, the primary objective of developing community based services and realigning the role of the institution in the total system has been identified. Strategies for implementation of goals must necessarily follow. Although the Developmental Center strategies are discussed separately from strategies for community development, both coincide and support each other, creating a coordinated and systematic approach.

The strategies for action are intended to be flexible enough to reflect and accommodate the cultural, economic and geographical characteristics of Tennessee, yet assure that development is consistent with stated philosophy and goal achievement. The balancing of priorities and targets coupled with the resources anticipated to be available over the next five years became a planning challenge that, if successfully conquered, will transform a formal governmental plan or statement into dramatic and dynamic action in behalf of mentally retarded citizens of Tennessee.

CHANGE FOR THE INSTITUTION

The new model for services that has been presented is founded on a general acceptance of the mentally retarded person as a developable human being whose needs and rights are not unlike any other citizen. The new model must provide whatever resources are required to assure the realization of these rights. One of the major existing resources available is the institution. The institutions have a vital role to play in the success of the community model for delivery of services. However, the role perceived is that of a developmental center. The strategies to insure orderly progression by each institution toward this stated end is the point at hand. The strategies will vary according to the circumstances of each of the three Developmental Centers. Factors such as the condition and suitability of physical facilities, the results of years of neglect in provision of adequate operating funds, geographical locations, current resources available to support change and many others serve to justify variations in strategies and in the development of timetables for goal achievement. However, these variations become insignificant when the overall objectives are constant and the envisioned model of services materializes.

Arlington Developmental Center. Arlington Developmental Center is closer to achieving its proper position in the master plan than the other two institutions. The physical plant, although designed on the traditional institutional model, can be made appropriate to specialized programming with only a minimum of construction, basically for the purpose of providing more area for training activities. Staffing ratios and functions are near the standards of AC/FMR. Tennessee has taken care not to compromise the human and financial investment at Arlington and relegate it to traditional institutional status.

Arlington currently has a capacity of 640 beds utilized primarily for the severely handicapped, young mentally retarded person. An eventual goal of the Division suggests a need for only 500 beds at Arlington to serve the West Tennessee Service Area. The target is not unrealistic, although achievement during the five year planning period (1974-79) is doubtful because of the unmet needs for residential services in West Tennessee. Arlington currently has over 250 applicants for residential services on an urgent priority waiting list. Eight hundred others who need service are on a lower priority waiting list. In addition, over 200 mentally retarded adults are residing inappropriately at Western State Psychiatric Hospital and 240 West Tennesseans continue to reside at Clover Bottom Developmental Center in Middle Tennessee. Therefore, residential services will, in all probability, continue at present capacity for several years.

Another strategy, basic to the overall plan to fulfill a high degree of unmet needs with minimal resources, is the prescriptive admission of clients for specific, intensive programs and short time intervals. Such admission, perhaps in contract form, would allow a vast extension of services and great client turnover in the complex and expensive programs currently in operation at Arlington. After intensive, prescriptive training, the client could return to his home, or other community living and/or training facility. Return visits to Arlington for special training or treatment could be available if needed.

The program at Arlington Developmental Center should assume the following characteristics within the next five years (1974-79).

1. Retention of approximately 640 residential beds.
2. Extension of needed programming for ambulatory, severely and profoundly retarded adults.
3. Additional needed programming for the severely retarded, non-

ambulatory residents.

4. Additional services for the mildly retarded, behaviorally disturbed.
5. Increased turnover of older stabilized residents into community located residential facilities, as they are developed, with a younger resident, primarily in the severe mental retardation ranges, both ambulatory and non-ambulatory, who would be admitted for intermediate periods of time with specific training and treatment goals.
6. Great extension of supportive services to community programs. These include social and psychological services, diagnostic and evaluation services, public information, program consultation and monitoring, planning, manpower training with regular workshops and seminars for community staff personnel.
7. Extension, in partnership with local universities, of training for professional persons and the conduct of research.

Per diem costs for residential services at Arlington Developmental Center should stabilize during the next five years with only an accepted inflationary factor added. An annual two percent improvement factor has been projected to account for increased expenditures anticipated through the provision of supportive services to community based programs. By F.Y. 1978 - 79, program costs at Arlington Developmental Center should be approximately thirteen million dollars. With these dollars, Arlington proposes to provide the highest quality, fully accredited programming services to 896 residents (developed by estimating a 40% annual turnover in the use of 640 beds through short term intensive programs). In addition, out-resident services are projected for 780 clients and supportive services for 1,513 mentally retarded West Tennesseans living in or near their home communities.

Clover Bottom Developmental Center. Clover Bottom Developmental Center presently finds itself in a transitional phase of development; these changes are evident in all areas of operation. The Center is moving from a philosophy of custodial care to an habilitative approach to programming. The physical plant is primarily old and outmoded. The multi-story buildings with their large open wards do not lend themslves to training programs and do not fulfill the intent of the principle of normalization. To overcome these difficulties and to pave the way for Clover Bottom to assume its proper role in the new model of services, a program of construction and renovation has been initiated. Old buildings will be razed and new cottages constructed, each housing no more than 25 residents in a more normalized environment. Activity buildings to provide programming space are planned and many other areas will be remodeled or otherwise adjusted to fit new requirements as Clover Bottom undergoes the reorientation involved in the reversal of 50 years of operation.

During the past few years, with the support of the Governor and Legislature, significant strides have been taken to correct the critical staff shortages and deficits in staff training which have inhibited Clover Bottom's ability to provide proper care or training for residents.

Even without renovation, the physical plant at Clover Bottom was designed for a maximum of 800 residents. However, at one time, over 1,400 mentally retarded persons lived on-grounds. Intensive efforts at reducing the number of residents, and especially at returning persons who were inappropriately institutionalized, have yielded a current census of fewer than one thousand. The goal of Clover Bottom is an on-grounds resident capacity of approximately 750 clients. The renovation plans will allow for this goal and the services planned for provision in the communities of Middle Tennessee should enable the realization of the goal by 1979. Clover Bottom Developmental Center also plans a strategy in the overall

design of programs and services offered to the mentally retarded citizens of Middle Tennessee that fully meets accreditation standards promulgated by AC/FMR. However, such standards will probably not be attainable until after reconstruction of the Center.

Fifty to sixty new staff positions will be required over the next three year period to meet accreditation standards. Incremental increases in the level of spending for Clover Bottom Developmental Center will be necessary and should serve to raise the per diem cost per resident by only approximately ten dollars over the five year planning period. The use of some of these monies will be devoted to supportive services for community based programs. The development of new programming ideas at Clover Bottom will first center on skills for everyday living for residents returning to the community.

Recent publicity, often adverse, concerning conditions at Clover Bottom aroused the public's interest and concern over a problem that had resulted from years of neglect. The additional interest and the rapid influx of additional monies into the institution enabled the improvements in staffing and programs that currently will become the foundation for change.

Greene Valley Developmental Center. Greene Valley Developmental Center has made significant progress in the implementation of habilitation programs for residents of the Center despite the inadequacies of the physical plant, staffing shortages, and financial resources. Extensive renovation is in order for Greene Valley Developmental Center so that the physical plant can accommodate new programming and resident living arrangements. Resident living areas must be remodeled to provide residents with a more homelike environment. Large cottage areas will be renovated into small bedroom units and activity rooms. In addition, new training and activity areas will be required if appropriate habilitation programs are to be offered.

Greene Valley is currently overcrowded and a reduction of the on-grounds population to approximately 750 is imperative if Greene Valley is to achieve full accreditation by AC/FMR. As alternative placements in the community are secured for residents, a reallocation of resources should expedite some on-grounds programming improvements without additional expenditure of funds. Staff can be reassigned or staffing patterns adjusted. Funds designated for custodial purposes (food, clothing, and so forth) can be reallocated into programming areas for those residents who should remain at Greene Valley Developmental Center.

However, even after significant reductions in population, increased appropriations to Greene Valley will be necessary to enable the delivery of the quality of care and training required by accreditation standards. Currently, the per diem cost per resident at Greene Valley is the lowest of the three Developmental Centers. Federal funds secured through industrious efforts of the Center personnel have been the major provider of programming services.

ACTION FOR THE COMMUNITY

The cities and communities of Tennessee must prepare to meet the challenge of providing a broad array of services, organized into a comprehensive system of service delivery. It is not feasible to look to the Department of Mental Health to provide one hundred percent of the services needed by mentally retarded persons. Experience with development of community programs over the past five years has proven the task not to be too formidable for challenge and many communities of Tennessee are ready for action. While an accurate assessment of community readiness and receptivity to the provision of services to mentally retarded citizens is difficult at this stage of the Division's planning effort, a strategy for community services development can be determined. The strategy outlined is intended not only to systematize the Division's approach to community services, but also to stimulate communities in Tennessee to respond to the plan with decisive action which will result in development of the full array of services needed by mentally retarded individuals.

Targets for Action - Clients. A basic determination of the clientele group to receive top priority for action in the provision of services precedes the development of strategies. With the advent of Education for the Handicapped legislation to be implemented by Fall, 1974, coupled with changes in Title IV-A of the Social Security Act and the eventual inclusion of many clients now served by day training programs into special education classes, the Division of Mental Retardation has targeted the severely and profoundly mentally retarded adult as the first priority for concentrated action in the development of appropriate community services. Long neglected by social systems that denied appropriate training opportunities, mentally retarded adults are targeted for action in the Division's plan which emphasizes sheltered employment programs, adult training or day activity

programs and residential services heretofore non-existent for them.

Other targets assuming importance are the severely and profoundly mentally retarded child of preschool age (birth to four years), mentally retarded citizens with needs for specialized services unavailable from any other resource, and the mentally retarded of all ages who are inappropriately placed in institutions.

Targets for Action - Services. First and foremost in the overall strategy for service delivery is the concept that mentally retarded persons should be encouraged to utilize existing generic services available to the general population of the community. Most mentally retarded persons do not require complex or special assistance in everyday situations but use of generic services does not rule out the requirement for specialized services designed to meet specific needs of mentally retarded individuals. However, access of mentally retarded persons to health, educational, vocational, rehabilitative and many other types of services offered by generic agencies in the community reduces the need for development of highly specialized services for many clients whose needs might be met more appropriately and with less expense elsewhere.

All services provided to meet some aspect of the total needs of mentally retarded citizens within a given location should be organized and coordinated adequately for the development of a system of services, and services should be planned to complete the array of services necessary for a comprehensive program in a given area. Since the needs of mentally retarded individuals vary extensively according to a multiplicity of factors, a wide range of services must be made available in any given locality.

All facilities, programs or services for mentally retarded persons should be planned to meet or exceed any requirement which may exist for state grants, state or federal statute, accreditation, licensure, but most of all, the morally-controlled requirements of human decency and individual dignity.

In addition, any facility, program, or service for mentally retarded individuals should be planned and implemented in accordance with the philosophy concerning the developmentally disabled accepted by the Division of Mental Retardation.

The strategies for community action are designed to provide programs and services to supplement or fill gaps in service delivery where generic services are inappropriate or unavailable. Four types of services have been chosen as targets for development in the community because no other agency or organization has direct responsibility for meeting these specific needs. The provision of these four community based services will lay the foundation for the development of a comprehensive system of services, such system being developed only after all agencies that are components of the desired services system coordinate their efforts in behalf of mentally retarded persons. The services provided through the Department of Mental Health constitute only a portion of the elements included in a total delivery system, yet the Department feels the obligation to guide, assist, and contribute to the development of the system in every way possible.

Adult activity centers were developed with funding under Title XIV of the Social Security Act. Serving the severely retarded adult incapable of competitive employment, the adult activity centers already established present themselves as a strong base for the development of sheltered workshops for mentally retarded individuals, while concurrently providing day activities for adults incapable of even marginal productivity.

Sheltered workshops provide day employment in a non-competitive environment for mentally retarded persons incapable of competitive employment or for vocational rehabilitation. Many mentally retarded adults who are likely to remain only marginally economically productive need this type work environment.

Residential placements in a variety of community living situations

have proven feasible and much more desirable for most mentally retarded persons than institutional life. The provision of a wide variety of alternative community residential services must accelerate at a rapid pace to forestall pressures for the construction of another institution to serve persons currently living in inappropriate situations and to expedite the movement of institutionalized residents back to the more appropriate community environment.

The fourth basic service to be targeted for action is the provision of programs for training of severely and profoundly mentally retarded preschool (age birth to 4 years) children with substantial handicaps. Although the general format for preschool training programs is still in developmental stages, such programs emphasize early intervention, parent counseling and training to achieve optimum successes. (See Appendix II for a description of each of the four types of programs.)

Location of Community Services. Working toward the goal of services in or near the home community of every mentally retarded citizen, several strategies were developed which have guided the planning effort.

Efficient and effective utilization of existing specialized services for mentally retarded persons must precede the implementation of new or expanded programming. New or expanded services should be layered upon existing quality programs; existing facilities and services should be improved, where feasible and appropriate. Factors such as effectiveness of program, adequacy of staff, and suitability of physical facilities and location should influence decisions concerning potential for program expansion.

All services and facilities for mentally retarded persons should be planned for ease in accessibility to the population to be served, minimizing travel, expense, and inconvenience. The location of facilities should also serve to foster more effective coordination and communication

with other related agencies and organizations (public and private) in the community. For this reason the concept of "clustering of services" in a given location was used in development of the community plan. The normalization principle should also apply to the location of facilities to serve mentally retarded individuals.

Population density and distribution played a prominent part in the planning effort. Programs in urban centers have little difficulty identifying clients with needs for specialized services and therefore provide the most strategic base for service development. For rural areas, satellite centers of a larger center were considered to conserve administrative cost and tie small programs into a system of services, while keeping the actual service close to the clients. Several isolated areas remain in the state after all factors influencing the plan were considered. Usually isolated geographically and possessing sparse population, these areas presented acute problem areas for decision. However, the provision of a day training activity for adults was considered of sufficient importance to overbalance the merits of the "clustering of services" concept. In some instances, neighboring counties may have to join forces to find adequate resources to support a program. Traffic patterns, transportation difficulties, traditional alignments among counties and counties' receptivity to cooperation with neighboring counties entered the final decisions for location of programs in rural areas.

Projected need for services based on statistical estimates concerning the number of mentally retarded persons guided the balancing of resources among the nine regions. The Northwest Tennessee Developmental Region has been designated by the Developmental Disabilities Service Act Advisory Council as a pilot project for demonstration of services in a rural area. Other factors influencing locational criteria of community based programs included the fact that areas with active Associations for Retarded Children

or strong special education departments in the local school system were given priority for program development in anticipation of strong local support. The same holds true for areas where desires for program development have already been expressed to the Department and in areas which support a college or university campus.

A final note to locational criteria for community services involves the regional boundaries. The use of regional boundaries has been adopted by the Division for administrative and planning use only, and the delineation of regional boundaries should not restrict accessibility to service for potential clients in the community.

Size of Programs. With the goal in mind of services adequate to meet need, the planned number of clients to be served in any given location was determined based on the statistical estimate of the number of severely retarded persons in the area to be served (county or combination of counties). Adult activity programs were necessarily kept small, since the intent of such programs is to serve the very low functioning adult. Workshops developed in conjunction with adult activity centers were usually projected to serve the larger number of clients since the normalized "factory" environment usually prevails. Planning for numbers of new clients in adult activity programs usually fell into six or multiples of six, based on standards for staff-client ratios.

For community residential placements, the planning figures for number of clients usually fall in the categories of four or six, or multiples thereof. Family-type living arrangements with only four to six residents in a home are the most desirable, and the development of small residential units facilitates the use of existing resources. By locating a four bedroom home in the community for programming use, the need for specialized construction is diminished, the environment is more "normalized" and the costs decrease.

In some urban areas, more than one program of any type may be needed to serve the projected number of clients. The number of clients listed in the plan for any community is the total number to be served by all units providing services therein. For example, 130 residential placements are planned for Knox County; however, it is in no way the Division's intention that any substantial number of residential placements be within the same facility. (See Appendix II)

The Timetable for Implementation. Strategies for the orderly progression toward the total number of clients to be served by F.Y. 1978 - 79 include the following points.

Adult activity centers must first be established, reach their maximum size, and then stabilize.

After the establishment of the adult activity center, a small workshop program usually is added to accommodate clients of the adult activity center who have grown in their capabilities. This movement provides openings in the adult activity program for new clients. The workshop can then continue to grow in size until it is actually being supported by the adult activity component, thus reversing the original roles.

Sufficient community residential placements were planned to support the workshop and adult activity programs in a given area. The "rule of thumb" used was one residential placement for every two adult activity and workshop clients. Residential units were usually planned for the year following the establishment of an adult activity program and increased thereafter until the planned number of clients was reached.

The entire strategy is based on the contention that day services must precede residential placements to assure that community life be more fulfilling than the idle ward life of the traditional institution. An adequate number of community residential placements are included in the plan to enable the return of inappropriately placed institutional residents

to the community as well as to provide alternatives to institutional placement for many clients on the waiting lists of the Developmental Centers. The lack of anticipated financial resources projected over the five year period and the need to develop day programs prevents the possibility of meeting the residential needs of all mentally retarded persons within the five year planning period.

A one year time lapse was often allowed before an expansion of existing services or addition of a supplementary service was planned in a given community. Development of community support was a factor in considering the time frame for program implementation. The laying of proper groundwork to educate the community and activate concerned citizenry can be a controlling factor in the eventual success of the program.

Projection of Estimated Costs. All cost figures for programs listed in the plan are estimates projecting total costs, regardless of funding sources. Currently, it would be misleading to attempt to allot the distribution of the total projected costs among the sources of revenue because of changes in federal funding arrangements, the inability to predict new federal sources of revenue that might become available in the next five years, the ability of local communities to share in the total cost projections and the interdepartmental funding arrangements that may ensue to further confuse the issue of cost allocation. The plan is designed merely to state what could feasibly be done if the dollar amounts indicated were available to meet the needs of the mentally retarded. It is believed that the total costs projected over the next five years are not unreasonable and are available from a variety of sources.

Currently, adult activity programs are funded under Title XIV of the Social Security Act on a 75% federal basis, administered through the Tennessee Department of Public Welfare. The remaining 25% of the cost is shared by the local community and the Department of Mental Health.

Funds for purchase of residential services have consisted mainly of state dollars; however, avenues have opened for joint support by the Department of Mental Health and the Department of Public Welfare of clients who may qualify for Aid to the Disabled and, if pursued, could render the planned residential strategy very conservative in number of clients who could be served over the five year planning period. Intermediate Care payments will be another resource for community residential placements, especially for cases requiring mainly nursing care, although it is anticipated that a state supplement to ICF payments may be required.

The estimated cost per client for sheltered workshop placements will likely consist of state dollars. The small amount reflects only a monthly allowance for each client, since it is anticipated that after establishment of the shop and full operation on contract work, the shop should reach a potential of near self-sufficiency.

Funds for establishment grants and demonstration projects, diagnostic and evaluation services, special programs, and recreational services were not included in the plan as shown on pages 58 through 86.

Table I shows the figures for estimated annual costs per client that were used in computations for total program costs. These figures are intended for use in planning and do not reflect actual variations in costs among programs. It is anticipated that by F.Y. 1974 - 75 a complete realignment in residential costs per client will become effective after the results of a current research project become available as a guide. Costs will then be prorated on the actual services provided to meet the needs of an individual client and costs among clients may vary by several hundred dollars per month. However, the $3,000 per year planning figure will probably retain its validity as an average cost.

Costs projected for preschool training programs are based on experience with day training programs operated under Title IV-A. Until a more

detailed study of the requirements of a preschool training program is undertaken, the estimates used will remain the most reliable. Costs for adult activity programming is also based on experiences with past and current programs and an assessment of reasonable programming needs and personnel costs yielded the $2,700 per year estimate.

The following chart lists the estimated annual cost per client served in community based programs. A seven percent annual inflation factor is computed for each year after F.Y. 1973 - 74. The estimates shown in Table I are rounded to the nearest $5 or $10.

TABLE I

ESTIMATED ANNUAL PROGRAM COSTS PER CLIENT

	Annual Cost Per Client					
Type of Program	FY 1973-74	74-75	75-76	76-77	77-78	78-79
Community Residential	$3,000	$3,200	$3,425	$3,665	$3,920	$4,200
Adult Activity	2,700	2,900	3,100	3,300	3,530	3,775
Sheltered Workshop	480	510	550	590	630	675
Preschool Training	3,300	3,530	3,775	4,040	4,325	4,625

Other Factors Affecting the Community Strategy.

1. Day Training. Title IV-A of the Social Security Act provided a source of funding that allowed the State of Tennessee to provide day training and care services to 698 mentally retarded children. During F.Y. 1973 - 74, 27 programs are in operation, with a total expenditure from all sources of $2,127,307. However, changes in federal regulations during 1973 threw many day training centers into a state of confusion regarding the future of the programs. Legislation requiring the Department of Education and the local school systems to provide educational services to all children of school age (age 4 to 21) is scheduled for full implementation by Fall, 1974. Most of the children served by Title IV-A Day Training

Centers will then be eligible for services of the local school system.

Because of the current instability of the day training situation, detailed planning for such was not included. When final decisions guiding the future of such centers are available, a detailed plan concerning the phasing-out of the Department of Mental Health's involvement in day training for school age youngsters will be developed. This plan will require the full cooperation of the Department of Mental Health, Department of Education, Department of Public Welfare, local school systems, day training center sponsors and persons representing solely the interests of clients. Several alternatives for day training centers can be offered, with the condition that these are only suggestions for detailed study. Day training centers can plan an orderly phase-out of all programming as clients are absorbed into special education programs. Day training centers can redesign programs and staffing patterns to meet requirements of the local school system and then serve as a contracting agency with the educational system. If community need is strong, centers might redesign programs to serve preschool age children with substantial handicaps associated with developmental disabilities, thus allowing a more orderly realignment of function or services while meeting a need for a specialized service provided by no other agency. Each individual program must be considered. In all probability the plan for day training centers must be determined during the early portion of 1974.

Another factor currently under discussion with implications for the planning process is the, as yet, undetermined question of the role of the Department of Education in the provision of preschool programming for mentally retarded children. Because of these unanswered questions, the uncertain future of day training programs and the new ground the Division is breaking in the area of early intervention and infant and toddler programs, most preschool projects included in the plan are projected for

1975 or later.

2. Construction for Community Programs. It is intended that construction of facilities in the community to house programs designed for mentally retarded persons be approached with caution. Although several projects are underway or in the final planning stages, the Department of Mental Health wishes to forestall a rapid build-up in community construction until prototypes for varying types of facilities have been developed and a more concise assessment of construction needs has been determined. The most urgent priority for construction is at Clover Bottom and Greene Valley Developmental Centers. Existing resources for community facilities to house programs have not yet been depleted. However, attention to the development of prototypes is needed in order to be prepared when priorities change.

Current construction policy for community programs is based on a 75% state and 25% local matching formula with the private, non-profit organization sharing in the project retaining ownership and control. All construction for community based facilities must be normalized to the fullest extent feasible and suited not only to the needs of clients but also to its location, purpose, and environment. All construction must reflect the Division's intent to integrate mentally retarded persons into the mainstream of community life.

3. Diagnostic and Evaluation Services. Diagnostic and evaluation services serve as the foundation for all training and programming for mentally retarded individuals. Only after a complete diagnostic assessment can service be recommended and provided which most appropriately meets the needs of a retarded person. (For a description of diagnostic and evaluation services, see Appendix IV). Adequate diagnostic and evaluation services must be planned to support the new service delivery model and expanded number of clientele receiving services.

At present, the East Tennessee Service Area has three centers with

comprehensive diagnostic and evaluation capabilities: Greene Valley Developmental Center in Greeneville, The University of Tennessee Birth Defects Center in Knoxville, and Team Evaluation Center in Chattanooga. Given the strategic location of a diagnostic and evaluation center in each developmental region of the East Tennessee Service Area, it will be possible for a family to obtain diagnostic services within reasonable traveling distance. If expansion of diagnostic and evaluation services should be indicated during the five year planning period, one approach might be the establishment of a satellite service for the Tri-Cities area.

Diagnostic and evaluation services are available in the Middle Tennessee Service Area at Clover Bottom Developmental Center and at the Meharry Medical complex. However, the diagnostic and evaluation unit at Meharry serves only a portion of the Metropolitan - Nashville population. At present, a minimum waiting period of two or three months is normal for a diagnostic and evaluation workup at Clover Bottom. A complete diagnostic and evaluation service, administratively attached to Clover Bottom, is planned for the South Central Developmental Region and another for the Upper Cumberland Region to fully meet service demands by 1978.

At this time, two diagnostic and evaluation centers provide diagnostic services for the twenty-one counties of West Tennessee: Arlington Developmental Center at Arlington and The University of Tennessee Child Developmental Center at Memphis. The necessity is foreseen for a third center to serve the Southwest Developmental Region. The service needs for the Northwest Developmental Region are yet to be fully ascertained. However, the utilization of a mobile diagnostic and evaluation unit or the creation of another center are two alternatives to be considered.

4. Transportation. Transportation appears to be an insurmountable problem when faced individually by each community program, but when challenged

on a statewide basis, a solution becomes more feasible.

The Easter Seal Society has been in the business of providing transportation for handicapped persons and is the first potential resource to consider in planning transportation services for community programs. A pilot project for a transportation system to serve the entire Northwest Developmental Region is currently underway and promises exciting achievements. Based on this experience, the Division of Mental Retardation intends to explore the possibility of aiding in the expansion of the Easter Seal Society's program to a statewide operation, if feasible. Federal funds are currently available for transportation for community programs. A concise transportation plan must be decided before application is made for such funds. Utilization of this resource would require only a small investment in state dollars to yield big returns.

5. Other Life Situations. Thus far in the discussion of the five year plan for service delivery, several needs of retarded persons have not been mentioned. The deletion of a specific discussion concerning religious services, recreation, participation in organized social activities and other factors is intended to illuminate the normalization approach. Instead of duplicating or creating facilities and programs to meet each type of specific need of mentally retarded individuals, existing resources should be utilized, thereby integrating mentally retarded persons into the mainstream of community life. It may be easier to settle for the traditional "special" program for mentally retarded citizens, but with consistent education and interpretation, the public will eventually see the advantages of serving the vast majority of mentally retarded citizens through normal life situations. In many instances, the ability of more severely handicapped persons to function in existing service programs has not been tested. Therefore, the necessary modifications for their participation may not be known.

It will be necessary for those involved in the habilitation of mentally

retarded individuals to take specific steps to unlock the doors to normal life situations which are often closed to handicapped persons.

1. The resources available in each community must be determined and an assessment made of the extent to which they are being used by mentally retarded persons.
2. Leaders responsible for the control and access of these resources should be contacted to determine their attitudes toward and their plans for mentally retarded citizens.
3. From this point, negotiations may be in order to reshape attitudes, to include mentally retarded individuals in on-going services and/or to develop special programs for mentally retarded persons.

EAST TENNESSEE DEVELOPMENTAL CENTER SERVICE AREA

The East Tennessee Developmental Center Service Area consists of 34 counties. It has the largest population of the three service areas and the most overcrowded Developmental Center seeking relief through community services. However, three major urban areas afford an opportunity for rapid development of community programs. The needs of Hamilton County area are nearer to being met than any other section of the state. This has transpired primarily because of the efforts of very concerned and motivated citizens of the area. Given the necessary resources, East Tennessee is ready to proceed rapidly toward the provision of needed community programs for mentally retarded persons.

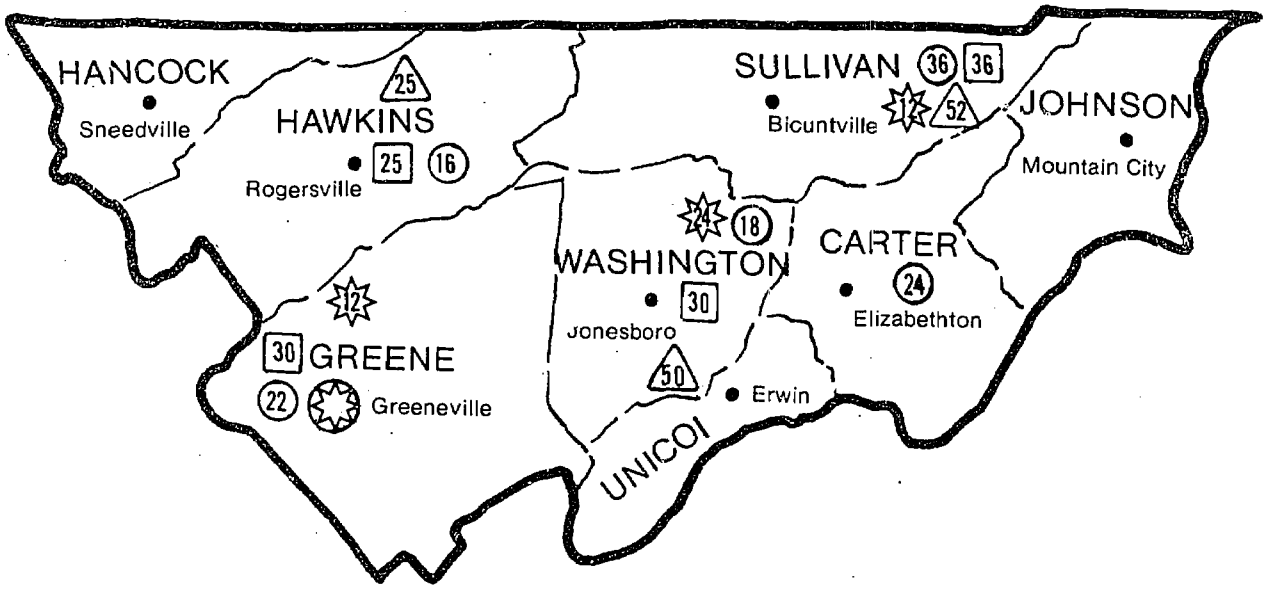
The Service Area is divided into three developmental regions:

First Tennessee Developmental Region

East Tennessee Developmental Region

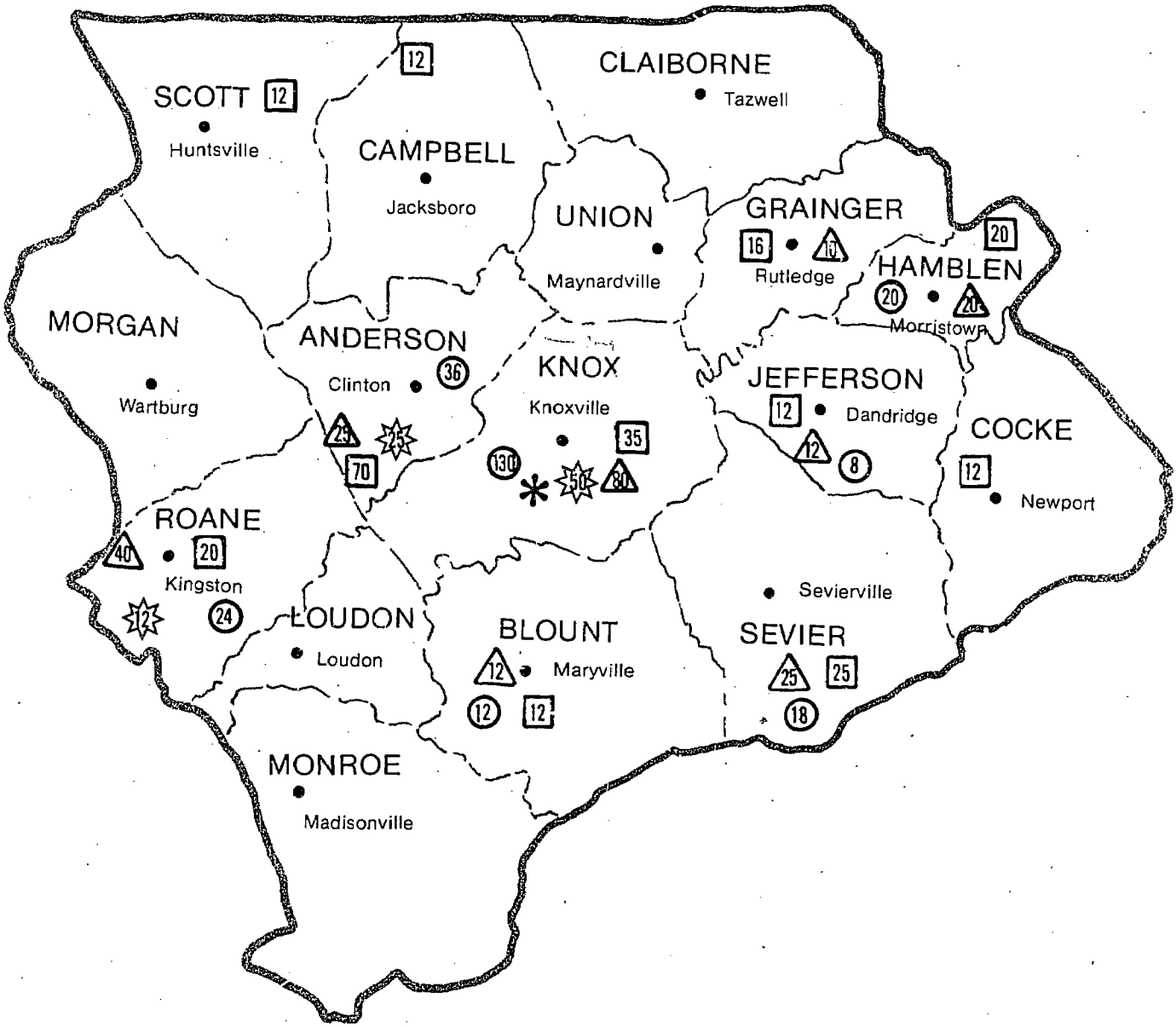
Southeast Tennessee Developmental Region

FIRST TENNESSEE DEVELOPMENTAL REGION



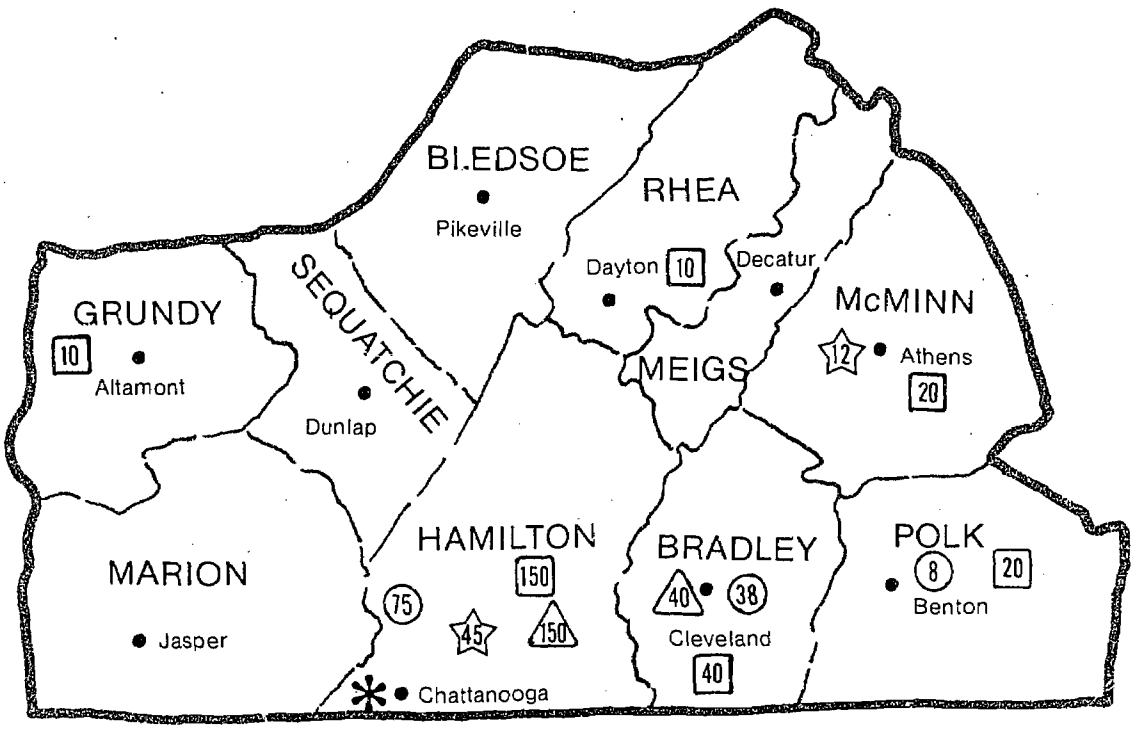
- ○ RESIDENTIAL
- □ ADULT ACTIVITY
- ✡ PRE-SCHOOL
- △ SHELTERED WORKSHOP
- ⊛ GREENE VALLEY DEVELOPMENTAL CENTER

EAST TENNESSEE DEVELOPMENTAL REGION



- ○ RESIDENTIAL
- □ ADULT ACTIVITY
- ✲ PRE-SCHOOL
- △ SHELTERED WORKSHOP
- * U T BIRTH DEFECT CENTER

SOUTHEAST DEVELOPMENTAL REGION



- ○ RESIDENTIAL
- □ ADULT ACTIVITY
- ☆ PRE-SCHOOL
- △ SHELTERED WORKSHOP
- ✻ TEAM EVALUATION CENTER

EAST TENNESSEE SERVICE AREA
PLAN FOR COMMUNITY PROGRAMS

FY 1973 - 74

FIRST TENNESSEE DEVELOPMENTAL REGION

Service	No. of Clients	County	Estimated Cost
Adult Activity	18	Hawkins	$ 48,600
Adult Activity	30	Greene	81,000
Adult Activity	20	Washington	54,000
Sheltered Workshop	12	Sullivan	5,760
Residential	12	Carter	36,000
Residential	10	Greene*	7,300
		FY 1973 - 74 Total	$232,660

EAST TENNESSEE DEVELOPMENTAL REGION

Adult Activity	70	Anderson	$189,000
Adult Activity	20	Roane	54,000
Adult Activity	20	Knox	54,000
Sheltered Workshop	25	Anderson	12,000
Sheltered Workshop	10	Roane	4,800
Sheltered Workshop	30	Knox	14,400
Residential	12	Anderson	36,000
Residential	4	Roane	12,000
Residential	25	Knox	75,000
Preschool	10	Knox	33,000
		FY 1973 - 74 Total	$484,200

SOUTHEAST TENNESSEE DEVELOPMENTAL REGION

Adult Activity	150	Hamilton	$405,000
Adult Activity	20	Bradley	54,000
Residential	8	Hamilton	80,000
Residential	17	Hamilton	51,000
Preschool	25	Hamilton	82,500
		FY 1973 - 74 Total	$672,500

EAST TENNESSEE SERVICE AREA
FY 1973 - 74 Total $1,389,360

*ICF ($2 day supplement to ICF payments for nursing home care)

EAST TENNESSEE SERVICE AREA
PLAN FOR COMMUNITY PROGRAMS

FY 1974 - 75

FIRST TENNESSEE DEVELOPMENTAL REGION

Service	No. of Clients	County	Estimated Cost
Adult Activity	(7)	Hawkins	$ 20,300
Adult Activity	(10)	Washington	29,000
Sheltered Workshop	(8)	Sullivan	4,080
Residential	(6)	Carter	19,200
Adult Activity	18	Sullivan	52,200
Residential	4	Sullivan	12,800
Residential	6	Washington	19,200
Preschool	12	Greene	42,360
		Total new programs	199,140
		continuation (7% increase)	248,946
		FY 1974 - 75 Total	$448,086

EAST TENNESSEE DEVELOPMENTAL REGION

Adult Activity	(10)	Knox	$ 29,000
Sheltered Workshop	(10)	Knox	5,100
Sheltered Workshop	(10)	Roane	5,100
Residential	(25)	Knox	80,000
Residential	(4)	Roane	12,800
Preschool	(10)	Knox	35,300
		Total new programs	167,300
		continuation (7% increase)	511,674
		FY 1974 - 75 Total	$678,974

SOUTHEAST TENNESSEE DEVELOPMENTAL REGION

Residential	(30)	Hamilton	$ 96,000
Sheltered Workshop	50	Hamilton	25,500
Sheltered Workshop	10	Bradley	5,100
Residential	8	Bradley	25,600
		Total new programs	152,200
		continuation (7% increase)	719,575
		FY 1974 - 75 Total	$871,775

* Parentheses indicate expansion of existing programs.

EAST TENNESSEE SERVICE AREA

total continuation	$1,480,195
total new programs	518,640
FY 1974 - 75 Total	$1,998,835

EAST TENNESSEE SERVICE AREA
PLAN FOR COMMUNITY PROGRAMS

FY 1975 - 76

FIRST TENNESSEE DEVELOPMENTAL REGION

Service	No. of Clients	County	Estimated Cost
Adult Activity	(18)	Sullivan	$ 55,800
Sheltered Workshop	(8)	Sullivan	4,400
Residential	(6)	Carter	20,550
Residential	(8)	Sullivan	27,400
Sheltered Workshop	15	Washington	8,250
Sheltered Workshop	10	Hawkins	5,500
Residential	6	Greene	20,550
Preschool	12	Washington	45,300
		Total new programs	187,750
		continuation (7% increase)	479,452
		FY 1975 - 76 Total	$667,202

EAST TENNESSEE DEVELOPMENTAL REGION

Adult Activity	(5)	Knox	$ 15,500
Sheltered Workshop	(10)	Roane	5,500
Residential	(20)	Knox	68,500
Residential	(8)	Roane	27,400
Residential	(8)	Anderson	27,400
Preschool	(10)	Knox	37,750
Adult Activity	20	Hamblen	62,000
Adult Activity	12	Blount	37,200
Preschool	25	Anderson	94,375
Preschool	12	Roane	45,300
		Total new programs	420,925
		continuation (7% increase)	726,502
		FY 1975 - 76 Total	$1,147,427

SOUTHEAST TENNESSEE DEVELOPMENTAL REGION

Adult Activity	(20)	Bradley	$ 62,000
Sheltered Workshop	(50)	Hamilton	27,500
Sheltered Workshop	(20)	Bradley	11,000
Residential	(10)	Hamilton	34,250
Preschool	12	McMinn	45,300
		Total new programs	180,050
		continuation (7% increase)	932,799
		FY 1975 - 76 Total	$1,112,849

* Parentheses indicate expansion of existing programs.

EAST TENNESSEE SERVICE AREA

total continuation	$2,138,753
total new programs	788,725
FY 1975 - 76 Total	$2,927,478

EAST TENNESSEE SERVICE AREA
PLAN FOR COMMUNITY PROGRAMS

FY 1976 - 77

FIRST TENNESSEE DEVELOPMENTAL REGION

Service	No. of Clients	County	Estimated Cost
Sheltered Workshop	(15)	Washington	$ 8,850
Sheltered Workshop	(10)	Hawkins	5,900
Sheltered Workshop	(8)	Sullivan	4,720
Residential	(8)	Sullivan	29,320
Residential	(6)	Washington	21,990
Preschool	(6)	Washington	24,240
Residential	4	Hawkins	14,660
		Total new programs	109,680
		continuation (7% increase)	713,906
		FY 1976 - 77 Total	$823,586

EAST TENNESSEE DEVELOPMENTAL REGION

Sheltered Workshop	(20)	Knox	$ 11,800
Sheltered Workshop	(10)	Roane	5,900
Residential	(20)	Knox	73,300
Residential	(4)	Roane	14,660
Preschool	(10)	Knox	40,400
Adult Activity	25	Sevier	82,500
Adult Activity	12	Jefferson	39,600
Sheltered Workshop	25	Sevier	14,750
Sheltered Workshop	10	Hamblen	5,900
Sheltered Workshop	6	Blount	3,540
Residential	4	Hamblen	14,660
Residential	4	Blount	14,660
		Total new programs	321,670
		continuation (7% increase)	1,227,747
		FY 1976 - 77 Total	$1,549,417

SOUTHEAST TENNESSEE DEVELOPMENTAL REGION

Sheltered Workshop	(50)	Hamilton	$ 29,500
Sheltered Workshop	(10)	Bradley	5,900
Residential	(8)	Bradley	29,320
Residential	(10)	Hamilton	36,650
Adult Activity	20	McMinn	66,000
		Total new programs	167,370
		continuation (7% increase)	1,190,748
		FY 1976 - 77 Total	$1,358,118

* Parentheses indicate expansion of existing programs.

EAST TENNESSEE SERVICE AREA

total continuation	$3,132,401
total new programs	598,720
FY 1976 - 77 Total	$3,731,121

EAST TENNESSEE SERVICE AREA
PLAN FOR COMMUNITY PROGRAMS

FY 1977 - 78

FIRST TENNESSEE DEVELOPMENTAL REGION

Service	No. of Clients	County	Estimated Cost
Sheltered Workshop	(8)	Sullivan	$ 5,040
Sheltered Workshop	(5)	Hawkins	3,150
Sheltered Workshop	(10)	Washington	6,300
Residential	(6)	Greene	23,520
Residential	(6)	Hawkins	23,520
Residential	(8)	Sullivan	31,360
Preschool	(6)	Washington	25,950
		Total new programs	118,840
		continuation (7% increase)	881,237
		FY 1977 - 78 Total	$1,000,077

EAST TENNESSEE DEVELOPMENTAL REGION

Sheltered Workshop	(10)	Knox	$ 6,300
Sheltered Workshop	(6)	Blount	3,780
Sheltered Workshop	(5)	Hamblen	3,150
Residential	(20)	Knox	78,400
Residential	(4)	Blount	15,680
Residential	(8)	Hamblen	31,360
Residential	(4)	Roane	15,680
Residential	(8)	Anderson	31,360
Preschool	(10)	Knox	43,250
Adult Activity	16	Grainger	56,480
Adult Activity	12	Campbell	42,360
Sheltered Workshop	6	Jefferson	3,780
Residential	12	Sevier	47,040
Residential	4	Jefferson	15,680
		Total new programs	394,300
		continuation (7% increase)	1,657,876
		FY 1977 - 78 Total	$2,052,176

SOUTHEAST TENNESSEE DEVELOPMENTAL REGION

Adult Activity	20	Polk	$ 70,600
Residential	8	McMinn	31,360
Residential	(8)	Bradley	31,360
		Total new programs	133,320
		continuation (7% increase)	1,453,186
		FY 1977 - 78 Total	$1,586,506

* Parentheses indicate expansion of existing programs.

EAST TENNESSEE SERVICE AREA

total continuation	$3,992,299
total new programs	646,460
FY 1977 - 78 Total	$4,638,759

EAST TENNESSEE SERVICE AREA
PLAN FOR COMMUNITY PROGRAMS

FY 1978 - 79

FIRST TENNESSEE DEVELOPMENTAL REGION

Service	No. of Clients	County	Estimated Cost
Sheltered Workshop	(8)	Sullivan	$ 5,400
Sheltered Workshop	(10)	Washington	6,750
Residential	(6)	Hawkins	25,200
Residential	(6)	Washington	25,200
Residential	(8)	Sullivan	33,600
Preschool	12	Sullivan	55,500
		Total new programs	151,650
		continuation (7% increase)	1,070,082
		FY 1978 - 79 Total	$1,221,732

EAST TENNESSEE DEVELOPMENTAL REGION

Sheltered Workshop	(10)	Knox	$ 6,750
Sheltered Workshop	(5)	Hamblen	3,375
Sheltered Workshop	(6)	Jefferson	4,050
Residential	(6)	Sevier	25,200
Residential	(4)	Jefferson	16,800
Residential	(8)	Anderson	33,600
Residential	(8)	Hamblen	33,600
Residential	(4)	Blount	16,800
Residential	(20)	Knox	84,000
Adult Activity	12	Cocke	45,300
Adult Activity	12	Scott	45,300
Sheltered Workshop	10	Grainger	6,750
		Total new programs	321,525
		continuation (7% increase)	2,195,828
		FY 1978 - 79 Total	$2,517,353

SOUTHEAST TENNESSEE DEVELOPMENTAL REGION

Residential	(12)	McMinn	$ 59,400
Residential	(8)	Bradley	33,600
Preschool	(20)	Hamilton	92,500
Adult Activity	10	Grundy	37,750
Adult Activity	10	Rhea	37,750
Residential	8	Polk	33,600
		Total new programs	252,000
		continuation (7% increase)	1,697,562
		FY 1978 - 79 Total	$1,949,562

* Parentheses indicate expansion of existing programs.

EAST TENNESSEE SERVICE AREA

total continuation	$4,963,472
total new programs	725,175
FY 1978 - 79 Total	$5,688,647

MIDDLE TENNESSEE DEVELOPMENTAL CENTER SERVICE AREA

The Middle Tennessee Developmental Center Service Area consists of forty counties which includes the state's capitol city of Nashville. Clover Bottom Developmental Center at Donelson has embarked on a program for rapid decrease of the Center's population. The result of this effort has been the development of more community residential placements with supportive day services in the Mid-Cumberland Developmental Region than in any other region. A pilot project for community development in the South Central Developmental Region promises to increase the amount of community interest and the number of community programs. The counties comprising the Upper Cumberland Developmental Region are designated poverty areas. In this region, services offered mentally retarded individuals are almost non-existent. The five year plan proposes a systematic and carefully determined approach to providing services to this area as quickly as possible.

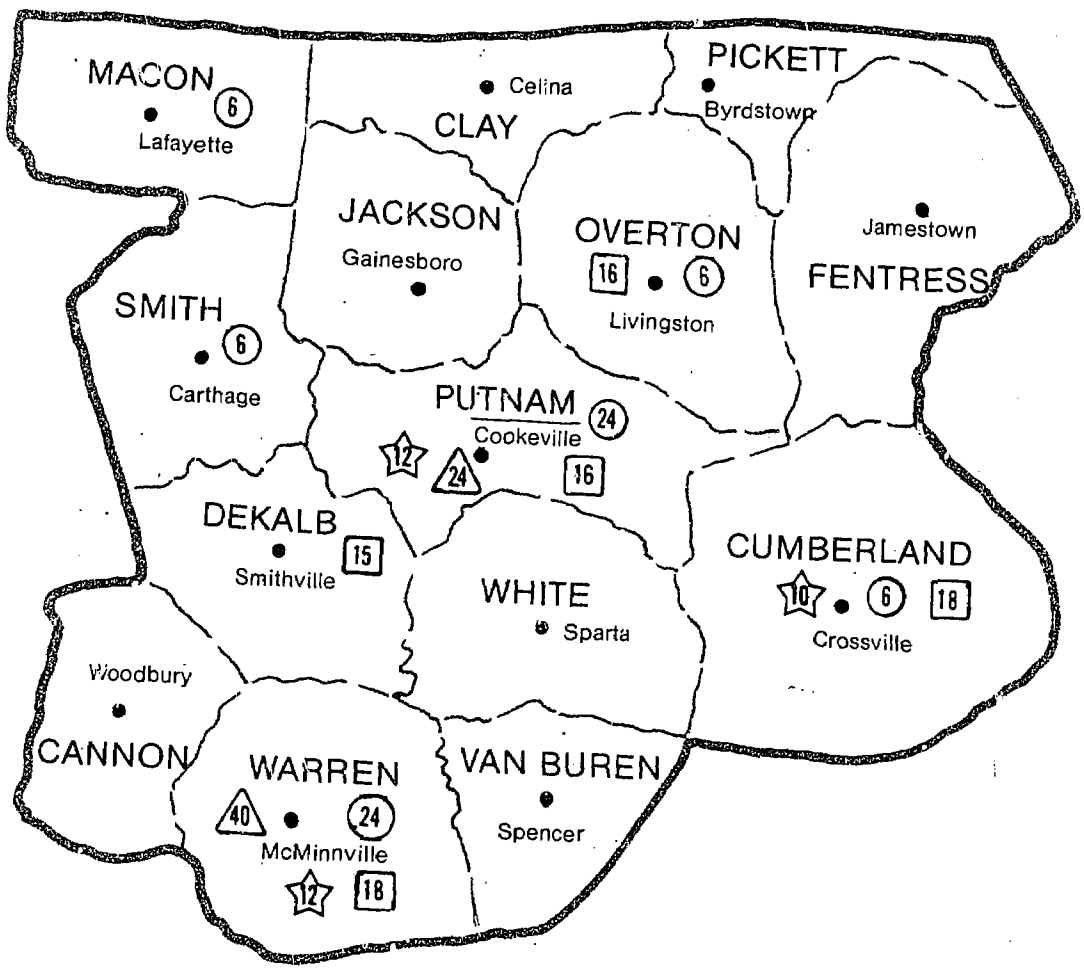
The Service Area is divided into three developmental regions:

Upper Cumberland Developmental Region

Mid-Cumberland Developmental Region

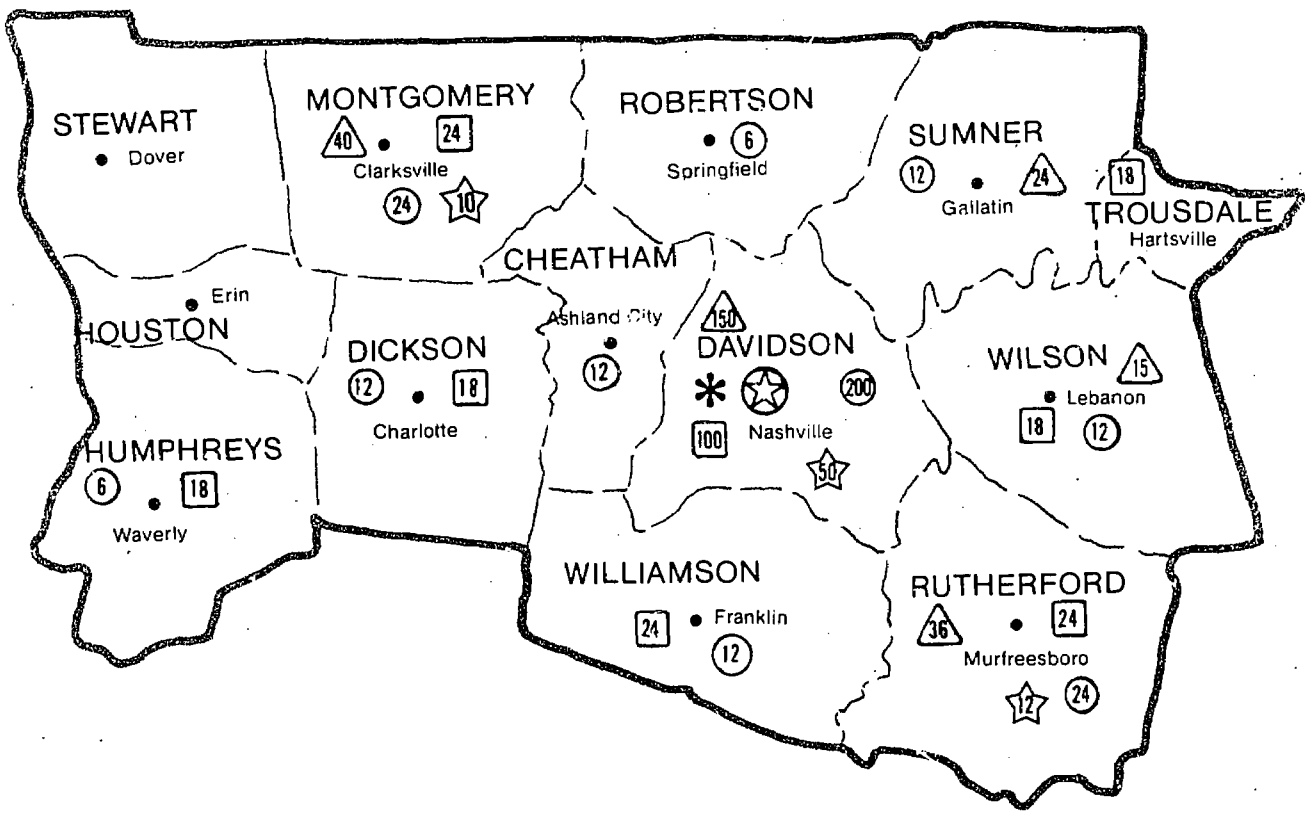
South Central Developmental Region

UPPER CUMBERLAND DEVELOPMENTAL REGION



○ RESIDENTIAL
□ ADULT ACTIVITY
☆ PRE-SCHOOL
△ SHELTERED WORKSHOP

MID-CUMBERLAND DEVELOPMENTAL REGION



○ RESIDENTIAL

□ ADULT ACTIVITY

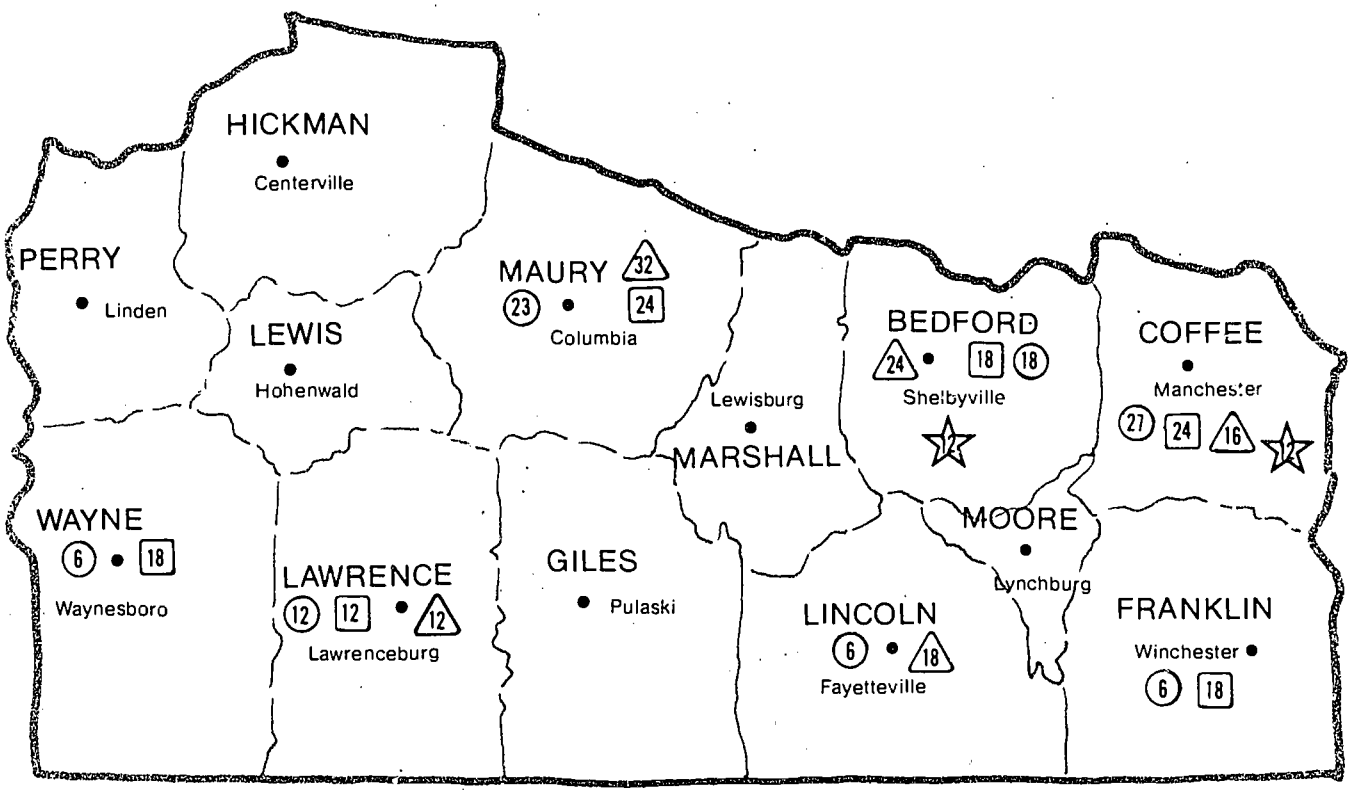
☆ PRE-SCHOOL

△ SHELTERED WORKSHOP

⊛ CLOVER BOTTOM DEVELOPMENTAL CENTER

✻ MEHARRY CHILD DEVELOPMENT CLINIC

SOUTH CENTRAL DEVELOPMENTAL REGION



○ RESIDENTIAL
□ ADULT ACTIVITY
☆ PRE-SCHOOL
△ SHELTERED WORKSHOP

MIDDLE TENNESSEE SERVICE AREA
PLAN FOR COMMUNITY PROGRAMS

FY 1973 - 74

UPPER CUMBERLAND DEVELOPMENTAL REGION

Service	No. of Clients	County	Estimated Cost
Adult Activity	15	Dekalb	$ 40,500
Adult Activity	16	Putnam	43,200
Adult Activity	16	Overton	43,200
		FY 1973 - 74 Total	$126,900

MID-CUMBERLAND DEVELOPMENTAL REGION

Adult Activity	18	Montgomery	$ 48,600
Adult Activity	18	Wilson	48,600
Adult Activity	18	Williamson	48,600
Adult Activity	12	Dickson	32,400
Adult Activity	100	Davidson	270,000
Sheltered Workshop	15	Wilson	7,200
Residential	110	Davidson	330,000
Residential	6	Williamson	18,000
		FY 1973 - 74 Total	$803,400

SOUTH CENTRAL DEVELOPMENTAL REGION

Adult Activity	20	Maury	$ 54,000
Adult Activity	18	Coffee	48,600
Adult Activity	18	Wayne	48,600
Residential	15	Coffee	45,000
Residential	11	Maury	33,000
		FY 1973 - 74 Total	$229,200

MIDDLE TENNESSEE SERVICE AREA

FY 1973 - 74 Total $1,159,500

MIDDLE TENNESSEE SERVICE AREA
PLAN FOR COMMUNITY PROGRAMS

FY 1974 - 75

UPPER CUMBERLAND DEVELOPMENTAL REGION

Service	No. of Clients	County	Estimated Cost
Adult Activity	18	Warren	$ 52,200
Sheltered Workshop	8	Putnam	4,080
Residential	6	Putnam	19,200
		Total new programs	75,480
		continuation (7% increase)	135,783
		FY 1974 - 75 Total	$211,263

MID-CUMBERLAND DEVELOPMENTAL REGION

Adult Activity	(6)	Dickson	$ 17,400
Adult Activity	(6)	Williamson	17,400
Adult Activity	(6)	Montgomery	17,400
Residential	(6)	Williamson	19,200
Residential	(20)	Davidson	64,000
Adult Activity	18	Humphreys	52,200
Adult Activity	18	Trousdale	52,200
Adult Activity	18	Rutherford	52,200
Sheltered Workshop	30	Davidson	15,300
Sheltered Workshop	8	Montgomery	4,080
Residential	6	Robertson	19,200
Residential	6	Cheatham	19,200
Residential	6	Rutherford	19,200
Residential	6	Dickson	19,200
Residential	6	Montgomery	19,200
Preschool	12	Rutherford	42,360
Preschool	25	Davidson	88,250
		Total new programs	485,790
		continuation (7% increase)	859,638
		FY 1974 - 75 Total	$1,345,428

SOUTH CENTRAL DEVELOPMENTAL REGION

Adult Activity	(6)	Coffee	$ 17,400
Adult Activity	(4)	Maury	11,600
Adult Activity	18	Bedford	52,200
Sheltered Workshop	12	Lincoln	6,120
Residential	6	Wayne	19,200
		Total new programs	106,520
		continuation (7% increase)	245,244
		FY 1974 - 75 Total	$351,764

* Parentheses indicate expansion of existing programs.

MIDDLE TENNESSEE SERVICE AREA

total continuation	$1,240,665
total new programs	667,790
FY 1974 - 75 Total	$1,908,455

MIDDLE TENNESSEE SERVICE AREA
PLAN FOR COMMUNITY PROGRAMS

FY 1975 - 76

UPPER CUMBERLAND DEVELOPMENTAL REGION

Service	No. of Clients	County	Estimated Cost
Sheltered Workshop	(8)	Putnam	$ 4,400
Residential	(6)	Putnam	20,550
Adult Activity	18	Cumberland	55,800
Sheltered Workshop	10	Warren	5,500
Residential	6	Warren	20,550
Residential	6	Smith	20,550
Residential	6	Macon	20,550
Residential	6	Overton	20,550
		Total new programs	168,450
		continuation (7% increase)	226,051
		FY 1975 - 76 Total	$394,501

MID-CUMBERLAND DEVELOPMENTAL REGION

Adult Activity	(6)	Rutherford	$ 18,600
Sheltered Workshop	(30)	Davidson	16,500
Sheltered Workshop	(8)	Montgomery	4,400
Residential	(6)	Cheatham	20,550
Residential	(20)	Davidson	68,500
Residential	(6)	Wilson	20,550
Residential	(6)	Rutherford	20,550
Residential	(6)	Dickson	20,550
Residential	(6)	Montgomery	20,550
Preschool	(25)	Davidson	94,375
		Total new programs	305,125
		continuation (7% increase)	1,439,608
		FY 1975 - 76 Total	$1,744,733

SOUTH CENTRAL DEVELOPMENTAL REGION

Sheltered Workshop	(6)	Lincoln	$ 3,300
Residential	(6)	Coffee	20,550
Sheltered Workshop	8	Maury	4,400
Sheltered Workshop	8	Coffee	4,400
		Total new programs	32,650
		continuation (7% increase)	376,387
		FY 1975 - 76 Total	$409,037

* Parentheses indicate expansion of existing programs.

MIDDLE TENNESSEE SERVICE AREA

total continuation	$2,042,046
total new programs	506,225
FY 1975 - 76 Total	$2,548,271

MIDDLE TENNESSEE SERVICE AREA
PLAN FOR COMMUNITY PROGRAMS

FY 1976 - 77

UPPER CUMBERLAND DEVELOPMENTAL REGION

Service	No. of Clients	County	Estimated Cost
Sheltered Workshop	(10)	Warren	$ 5,900
Sheltered Workshop	(8)	Putnam	4,720
Residential	(6)	Warren	21,990
Residential	(6)	Putnam	21,990
Preschool	12	Warren	48,480
		Total new programs	103,080
		continuation (7% increase)	422,116
		FY 1976 - 77 Total	$525,196

MID-CUMBERLAND DEVELOPMENTAL REGION

Sheltered Workshop	(30)	Davidson	$ 17,700
Sheltered Workshop	(8)	Montgomery	4,720
Residential	(6)	Wilson	21,990
Residential	(20)	Davidson	73,300
Residential	(6)	Montgomery	21,990
Residential	(6)	Rutherford	21,990
Sheltered Workshop	12	Sumner	7,080
Sheltered Workshop	18	Rutherford	10,620
Residential	6	Humphreys	21,990
		Total new programs	201,380
		continuation (7% increase)	1,866,864
		FY 1976 - 77 Total	$2,068,244

SOUTH CENTRAL DEVELOPMENTAL REGION

Sheltered Workshop	(8)	Coffee	$ 4,720
Sheltered Workshop	(8)	Maury	4,720
Residential	(6)	Coffee	21,990
Residential	(6)	Maury	21,990
Adult Activity	12	Lawrence	39,600
Sheltered Workshop	12	Bedford	7,080
Residential	6	Bedford	21,990
		Total new programs	122,090
		continuation (7% increase)	437,670
		FY 1976 - 77 Total	$559,760

* Parentheses indicate expansion of existing programs.

MIDDLE TENNESSEE SERVICE AREA

total continuation	$2,726,650
total new programs	426,550
FY 1976 - 77 Total	$3,153,200

MIDDLE TENNESSEE SERVICE AREA
PLAN FOR COMMUNITY PROGRAMS

FY 1977 - 78

UPPER CUMBERLAND DEVELOPMENTAL REGION

Service	No. of Clients	County	Estimated Cost
Sheltered Workshop	(10)	Warren	$ 6,300
Residential	(6)	Warren	23,520
Residential	6	Cumberland	23,520
Preschool	12	Putnam	51,900
		Total new programs	105,240
		continuation (7% increase)	561,960
		FY 1977 - 78 Total	$667,200

MID-CUMBERLAND DEVELOPMENTAL REGION

Sheltered Workshop	(30)	Davidson	$ 18,900
Sheltered Workshop	(8)	Montgomery	5,040
Sheltered Workshop	(18)	Rutherford	11,340
Sheltered Workshop	(6)	Sumner	3,780
Residential	(6)	Rutherford	23,520
Residential	(6)	Montgomery	23,520
Residential	(20)	Davidson	78,400
Residential	6	Sumner	23,520
Preschool	10	Montgomery	43,250
		Total new programs	231,270
		continuation (7% increase)	2,213,021
		FY 1977 - 78 Total	$2,444,291

SOUTH CENTRAL DEVELOPMENTAL REGION

Sheltered Workshop	(8)	Maury	$ 5,040
Sheltered Workshop	(12)	Bedford	7,560
Residential	(6)	Bedford	23,520
Adult Activity	18	Franklin	63,540
Sheltered Workshop	12	Lawrence	7,560
Residential	6	Lawrence	23,520
Residential	6	Lincoln	23,520
		Total new programs	154,260
		continuation (7% increase)	598,943
		FY 1977 - 78 Total	$753,203

* Parentheses indicate expansion of existing programs.

MIDDLE TENNESSEE SERVICE AREA

total continuation	$3,373,924
total new programs	490,770
FY 1977 - 78 Total	$3,864,694

MIDDLE TENNESSEE SERVICE AREA
PLAN FOR COMMUNITY PROGRAMS

FY 1978 - 79

UPPER CUMBERLAND DEVELOPMENTAL REGION

Service	No. of Clients	County	Estimated Cost
Sheltered Workshop	(10)	Warren	$ 6,750
Residential	(6)	Putnam	25,200
Residential	(6)	Warren	25,200
Preschool	10	Cumberland	46,250
		Total new programs	103,400
		continuation (7% increase)	713,904
		FY 1978 - 79 Total	$817,304

MID-CUMBERLAND DEVELOPMENTAL REGION

Sheltered Workshop	(6)	Sumner	$ 4,050
Sheltered Workshop	(30)	Davidson	20,250
Sheltered Workshop	(8)	Montgomery	5,400
Residential	(6)	Sumner	25,200
Residential	(10)	Davidson	42,000
		Total new programs	96,900
		continuation (7% increase)	2,615,391
		FY 1978 - 79 Total	$2,712,291

SOUTH CENTRAL DEVELOPMENTAL REGION

Sheltered Workshop	(8)	Maury	$ 5,400
Residential	(6)	Lawrence	25,200
Residential	(6)	Bedford	25,200
Residential	(6)	Maury	25,200
Residential	6	Franklin	25,200
Preschool	12	Bedford	55,500
Preschool	12	Coffee	55,500
		Total new programs	217,200
		continuation (7% increase)	805,927
		FY 1978 - 79 Total	$1,023,127

* Parentheses indicate expansion of existing programs.

MIDDLE TENNESSEE SERVICE AREA

total continuation	$4,135,222
total new programs	417,500
FY 1978 - 79 Total	$4,552,722

WEST TENNESSEE DEVELOPMENTAL CENTER SERVICE AREA

The West Tennessee Developmental Center Service Area is comprised of the twenty-one counties west of the Tennessee River. A primary influence on service delivery to mentally retarded citizens of West Tennessee is the divergent concentration of the population. On the one hand, Memphis-Shelby County has the largest population in the state, while the other 20 counties of the service area are the most sparsely populated in the state. West Tennessee is served by Arlington Developmental Center, the smallest state operated mental retardation facility. Waiting lists for services in West Tennessee are long and an intensive effort at providing new community programs in West Tennessee must be launched.

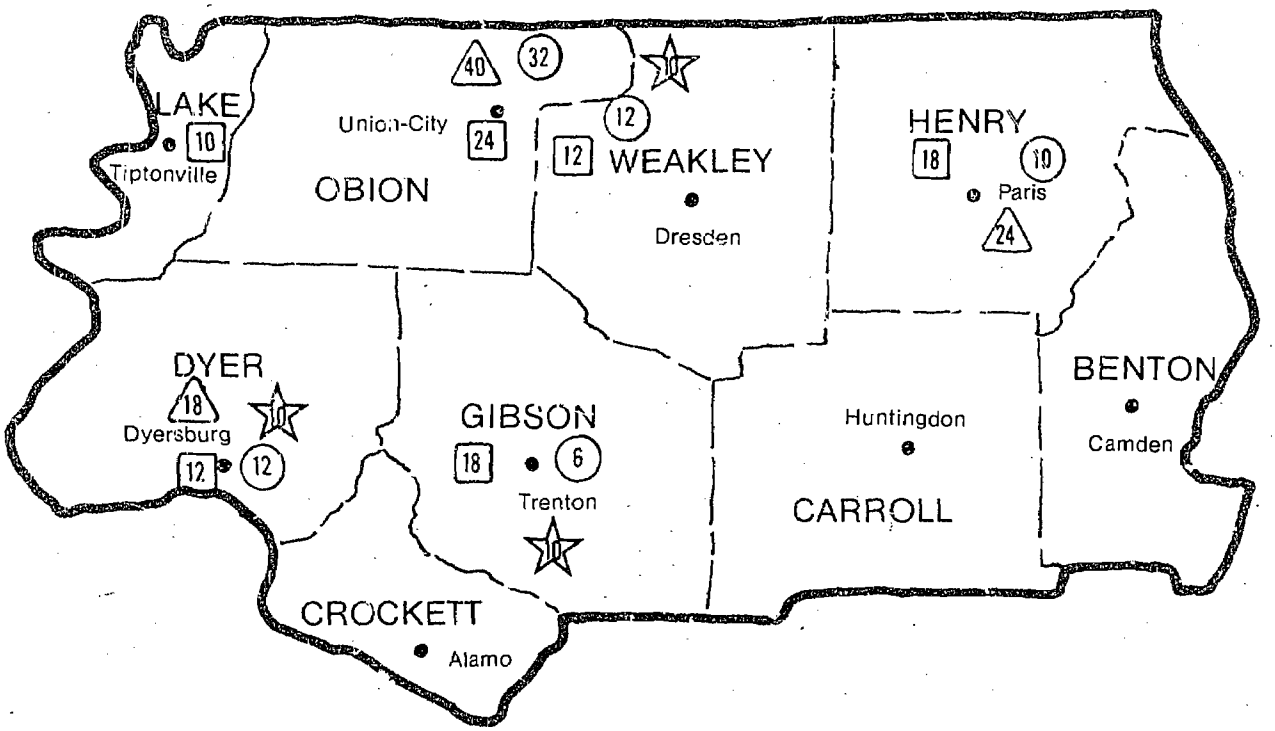
The Service Area is divided into three developmental regions:

Northwest Developmental Region

Southwest Developmental Region

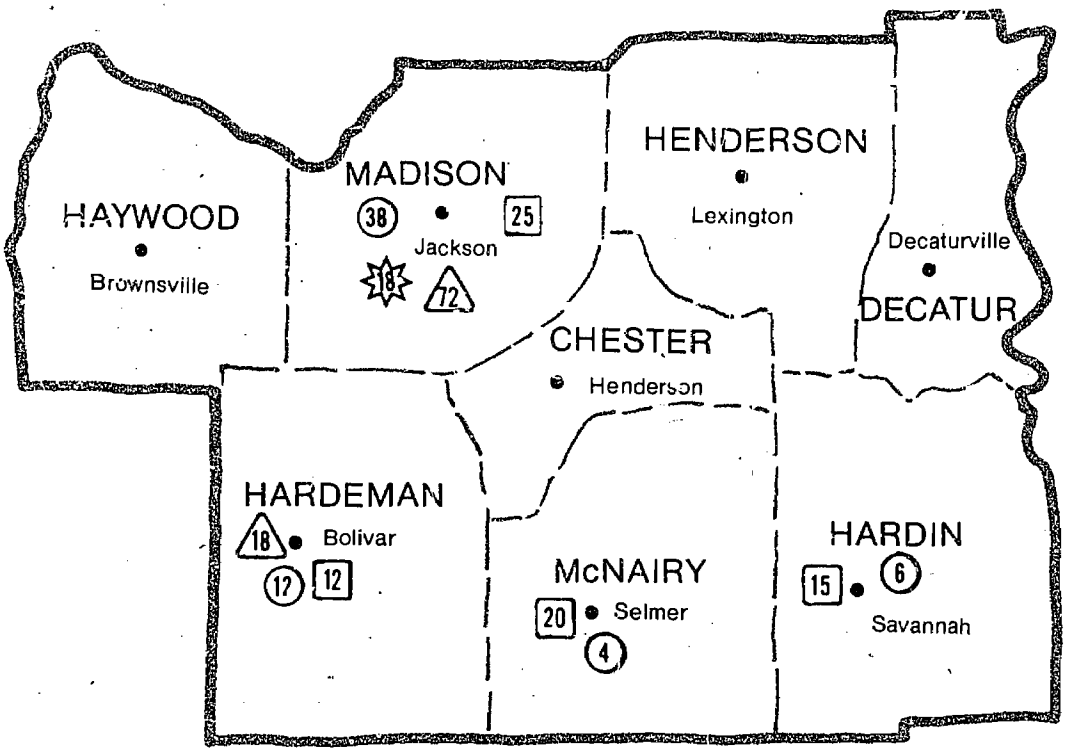
Memphis-Delta Developmental Region

NORTHWEST DEVELOPMENTAL REGION



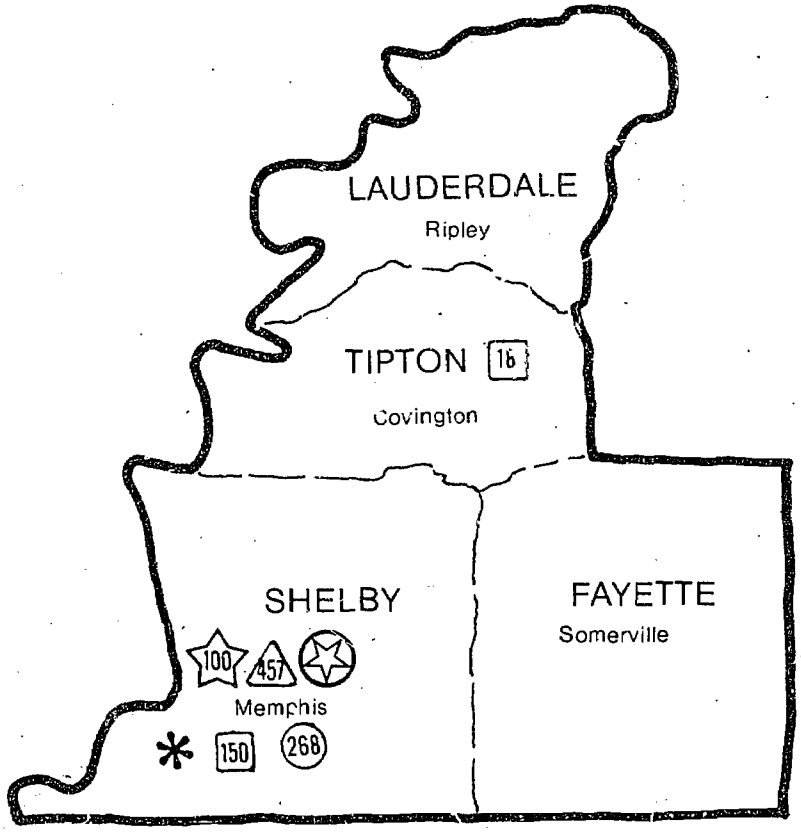
○ RESIDENTIAL
□ ADULT ACTIVITY
☆ PRE-SCHOOL
△ SHELTERED WORKSHOP

SOUTHWEST DEVELOPMENTAL REGION



○ RESIDENTIAL
□ ADULT ACTIVITY
PRE-SCHOOL
△ SHELTERED WORKSHOP

MEMPHIS DELTA DEVELOPMENTAL REGION



- ○ RESIDENTIAL
- □ ADULT ACTIVITY
- ☆ PRE-SCHOOL
- △ SHELTERED WORKSHOP
- ⊛ ARLINGTON DEVELOPMENTAL CENTER
- ✻ U T CHILD DEVELOPMENTAL CENTER

WEST TENNESSEE SERVICE AREA
PLAN FOR COMMUNITY PROGRAMS

FY 1973 - 74

NORTHWEST DEVELOPMENTAL REGION

Service	No. of Clients	County	Estimated Cost
Adult Activity	10	Lake	27,000
Adult Activity	20	Obion	54,000
Adult Activity	18	Henry	48,600
Adult Activity	18	Gibson	48,600
Residential	8	Obion	24,000
Residential	6	Henry	18,000
		FY 1973 - 74 Total	$220,200

SOUTHWEST DEVELOPMENTAL REGION

Adult Activity	25	Madison	67,500
Adult Activity	12	Hardeman	32,400
Adult Activity	20	McNairy	54,000
Adult Activity	15	Hardin	40,500
Residential	4	McNairy	12,000
Residential	8	Madison	24,000
		FY 1973 - 74 Total	$230,400

MEMPHIS-DELTA DEVELOPMENTAL REGION

Adult Activity	25	Shelby	67,500
Sheltered Workshop	188	Shelby	90,240
Residential	39	Shelby	117,000
		FY 1973 - 74 Total	$274,740

WEST TENNESSEE SERVICE AREA

FY 1973 - 74 Total $725,340

WEST TENNESSEE SERVICE AREA
PLAN FOR COMMUNITY PROGRAMS

FY 1974 - 75

NORTHWEST DEVELOPMENTAL REGION

Service	No. of Clients	County	Estimated Cost
Adult Activity	(4)	Obion	$ 11,600
Adult Activity	12	Lyer	34,800
Adult Activity	12	Weakley	34,800
Sheltered Workshop	12	Obion	6,120
Residential	8	Weakley	25,600
Residential	8	Obion	25,600
		Total new programs	138,520
		continuation (7% increase)	235,614
		FY 1974 - 75 Total	$374,134

SOUTHWEST DEVELOPMENTAL REGION

Residential	(6)	Madison	$ 19,200
Sheltered Workshop	12	Madison	6,120
Sheltered Workshop	10	Hardeman	5,100
Residential	6	Hardin	19,200
		Total new programs	49,620
		continuation (7% increase)	246,528
		FY 1974 - 75 Total	$296,148

MEMPHIS-DELTA DEVELOPMENTAL REGION

Adult Activity	(25)	Shelby	$ 72,500
Sheltered Workshop	(60)	Shelby	30,600
Residential	(24)	Shelby	76,800
		Total new programs	179,900
		continuation (7% increase)	293,972
		FY 1974 - 75 Total	$473,872

* Parentheses indicate expansion of existing programs.

WEST TENNESSEE SERVICE AREA

total continuation	$776,114
total new programs	368,040
FY 1974 - 75 Total	$1,144,154

WEST TENNESSEE SERVICE AREA
PLAN FOR COMMUNITY PROGRAMS

FY 1975 - 76

NORTHWEST DEVELOPMENTAL REGION

Service	No. of Clients	County	Estimated Cost
Sheltered Workshop	(8)	Obion	$ 4,400
Sheltered Workshop	6	Dyer	3,300
Sheltered Workshop	12	Henry	6,600
Preschool	10	Gibson	37,750
Preschool	10	Dyer	37,750
		Total new programs	89,800
		continuation (7% increase)	400,323
		FY 1975 - 76 Total	$490,123

SOUTHWEST DEVELOPMENTAL REGION

Sheltered Workshop	(8)	Hardeman	$ 4,400
Residential	(12)	Madison	41,100
Sheltered Workshop	24	Madison	13,200
Preschool	12	Madison	45,300
		Total new programs	104,000
		continuation (7% increase)	316,878
		FY 1975 - 76 Total	$420,878

MEMPHIS-DELTA DEVELOPMENTAL REGION

Adult Activity	(25)	Shelby	$ 77,500
Sheltered Workshop	(65)	Shelby	35,750
Residential	(75)**	Shelby	136,875
Residential	(25)	Shelby	85,625
		Total new programs	335,750
		continuation (7% increase)	507,043
		FY 1975 - 76 Total	$842,793

* Parentheses indicate expansion of existing programs.

WEST TENNESSEE SERVICE AREA

total continuation	$1,224,244
total new programs	529,550
FY 1975 - 76 Total	$1,753,794

** $5 day per diem supplement to ICF payment

WEST TENNESSEE SERVICE AREA
PLAN FOR COMMUNITY PROGRAMS

FY 1976 -

NORTHWEST DEVELOPMENTAL REGION

Service	No. of Clients	County	Estimated Cost
Sheltered Workshop	(6)	Dyer	$ 3,540
Sheltered Workshop	(10)	Obion	5,900
Residential	(8)	Obion	29,320
Residential	(4)	Henry	14,660
Residential	6	Gibson	21,990
Residential	6	Dyer	21,990
Residential	6	Weakley	21,990
Preschool	10	Weakley	40,400
		Total new programs	159,790
		continuation (7% increase)	524,432
		FY 1976 - 77 Total	$684,222

SOUTHWEST DEVELOPMENTAL REGION

Sheltered Workshop	2)	Madison	$ 7,080
Residential	)	Madison	21,990
Preschool	(6)	Madison	24,240
Residential	6	Hardeman	21,990
		Total new programs	75,300
		continuation (7% increase)	450,339
		FY 1976 - 77 Total	$525,639

MEMPHIS-DELTA DEVELOPMENTAL REGION

Adult Activity	(25)	Shelby	$ 82,500
Sheltered Workshop	(58)	Shelby	34,220
Residential	(35)	Shelby	128,275
Adult Activity	18	Tipton	59,400
Preschool	100	Shelby	404,000
		Total new programs	708,395
		continuation (7% increase)	901,789
		FY 1976 - 77 Total	$1,610,184

* Parentheses indicate expansion of existing programs.

WEST TENNESSEE SERVICE AREA

total continuation	$1,876,560
total new programs	943,485
FY 1976 - 77 Total	$2,820,045

WEST TENNESSEE SERVICE AREA
PLAN FOR COMMUNITY PROGRAMS

FY 1977 - 78

NORTHWEST DEVELOPMENTAL REGION

Service	No. of Clients	County	Estimated Cost
Sheltered Workshop	(10)	Obion	6,300
Sheltered Workshop	(6)	Dyer	3,780
Sheltered Workshop	(6)	Henry	3,780
Residential	(6)	Dyer	23,520
Residential	(8)	Obion	31,360
		Total new programs	68,740
		continuation (7% increase)	732,118
		FY 1977 - 78 Total	$800,858

SOUTHWEST DEVELOPMENTAL REGION

Sheltered Workshop	(12)	Madison	$ 7,560
Residential	(6)	Madison	23,520
Residential	(6)	Hardeman	23,520
		Total new programs	54,600
		continuation (7% increase)	562,434
		FY 1977 - 78 Total	$617,034

MEMPHIS-DELTA DEVELOPMENTAL REGION

Adult Activity	(25)	Shelby	88,250
Sheltered Workshop	(86)	Shelby	54,180
Residential	(35)	Shelby	137,200
		Total new programs	279,630
		continuation (7% increase)	1,722,897
		FY 1977 - 78 Total	$2,002,527

* Parentheses indicate expansion of existing programs.

WEST TENNESSEE SERVICE AREA

total continuation	$3,017,449
total new programs	402,970
FY 1977 - 78 Total	$3,420,419

WEST TENNESSEE SERVICE AREA
PLAN FOR COMMUNITY PROGRAMS

FY 1978 - 79

NORTHWEST DEVELOPMENTAL REGION

Service	No. of Clients	County	Estimated Cost
Sheltered Workshop	(6)	Henry	$ 4,050
		Total new programs	4,050
		continuation (7% increase)	856,918
		FY 1978 - 79 Total	$860,968

SOUTHWEST DEVELOPMENTAL REGION

Sheltered Workshop	(12)	Madison	$ 8,100
		Total new programs	8,100
		continuation (7% increase)	660,226
		FY 1978 - 79 Total	$668,326

MEMPHIS-DELTA DEVELOPMENTAL REGION

Adult Activity	(25)	Shelby	$ 94,375
Residential	(35)	Shelby	147,000
		Total new programs	241,375
		continuation (7% increase)	2,142,704
		FY 1978 - 79 Total	$2,384,079

* Parentheses indicate expansion of existing programs.

WEST TENNESSEE SERVICE AREA

total continuation	$3,659,848
total new programs	253,525
FY 1978 - 79 Total	$3,913,373

Supporting The Challenge

CHAPTER IV

SUPPORTING THE CHALLENGE

There are several supportive systems necessary to successfully meet the challenge of providing services for mentally retarded citizens. Although management and support services are a step removed from direct client service, they are often the measures which insure the realization of objectives and validity of ideas within the total framework of action. There must be assurance of orderly progression toward stated objectives, and controls are necessary to guarantee accountability for the decisions and activities of those responsible for direct services. Each of these factors, standing alone or in combination, presents a unique and perpetual challenge -- a challenge that must be continually faced, overcome and redefined. Separation of supportive services from direct services is difficult to effect since all factors influencing the life and future of mentally retarded citizens are so interwoven.

What are the implications for management and control functions of the new model for service delivery? Who must bear the ultimate responsibility and be held accountable for the status of affairs concerning the mentally retarded? What systems must be redesigned or developed to support the new service delivery model?

Central Office Responsibilities

Developmental Centers have been given responsibility for the development and provision of community services for mentally retarded citizens. The role of the Central Office of the Division of Mental Retardation must also

undergo a redefinition of function and responsibility. Via this five year plan, many new areas of responsibility, heretofore vested in Central Office, have been assigned to the Developmental Centers. Decentralization will permit Central Office greater involvement in overall planning, monitoring and policy formation in matters affecting mentally retarded citizens at both the state and national levels.

1. The Central Office is in the most advantageous position to remain apprized of the most recent development in legislation and litigation pertaining to the human and legal rights of mentally retarded persons and must constantly seek to preserve and protect these rights.
2. The Central Office must protect the interests of all mentally retarded citizens: balancing resources with needs, acting as leveler when inconsistencies in methods or goals occur, and coordinating the plans and services of each component of the service system.
3. The Department of Mental Health must provide systematic fiscal and program audits for all components of the delivery system. Although on-going monitoring and evaluation of community programs will be provided through the community services section of each Developmental Center, Central Office must provide unbiased periodic assessments of the system as a whole, propose necessary adjustments and furnish feedback and administrative control to the regional administrative system.
4. Division of Mental Retardation staff must strive to foster better cooperation, coordination and liaison with other human service agencies. Examples of such efforts might be the development of joint funding or program operational methods for use in the community, coordination with other state agencies to assure no duplication of efforts in serving clientele, or development of manpower conservation efforts by pooling resources of departments.

5. In the interest of continuity, the Division of Mental Retardation should cooperate with the Developmental Centers in the creation and continual revision of administrative manuals, publications and other forms of communications. The Central Office must also maintain responsibility for exchanging information with other states.
6. The Central Office must remain constantly informed concerning sources of governmental funding on all levels and changes in legislation which affect mentally retarded citizens.
7. In-service training for personnel can be provided or coordinated by the Division of Mental Retardation in cooperation with the Developmental Centers, community programs, other states or the federal government.
8. Central Office must remain prepared to offer the Governor, General Assembly, other state officials, and the public any advice and consultation requested concerning mental retardation.
9. The Division must strive to maintain and foster an open, honest, and continuous exchange of ideas with representatives of the consumer interest.

Implementation of the plan as outlined for the Central Office will require little escalation in staff, although a realignment of existing staff functions may be warranted. In terms of manpower, as well as funds for improvements, increases would be insignificant in comparison to expenditures in implementation of the service delivery plan.

Research and Development

Funds for most research and demonstration projects conducted in Tennessee have been provided primarily through the use of federal grants. Furthermore, the amounts devoted to scientific research have been almost negligible.

Federal demonstration monies have usually been earmarked for a specific purpose, such as demonstration of the feasibility of community alternatives to institutionalization. The Federal Government will continue to support some research but because of the revenue sharing approach, states will be expected to also assume research responsibilities. There are several top-level resources for research in Tennessee that are currently not utilized to the fullest. These include The University of Tennessee Child Development Center at Memphis, The John F. Kennedy Center for Research on Education and Human Development at George Peabody College at Nashville, The University of Tennessee Medical Units in Memphis, George Peabody College for Teachers, Vanderbilt, Fisk, and Meharry Universities in Nashville and The University of Tennessee at Knoxville.

Several areas can be delineated where research is needed but the following list is not intended to be inclusive.

1. Genetic and biomedical research concerning causes of mental retardation.
2. Relationship of diet and nutrition to cognitive development.
3. Metabolic disorders as a cause of mental retardation.
4. Instruments to measure extent and nature of handicaps, useful in both prevention of mental retardation and prescriptive programming for mentally retarded persons. Examples would include psychological and behavioral testing as well as instruments or machinery for monitoring or exploring physical neurological processes.
5. Learning theory as it relates to cognitive development of mentally retarded persons.
6. Development and perfection of service delivery systems.
7. Training methods and materials necessary for prescriptive programming for mentally retarded persons.

State funds designated for mental retardation research should be channeled through the Division of Training and Research in cooperation and consultation with the Division of Mental Retardation of the Department of Mental Health. Research

grants should be awarded by the Division to projects which promise results of statewide significance or application. It is proposed that $100,000 be appropriated during FY 1974-75 to the Central Office for research and demonstration. These funds might then be increased according to the following schedule:

$ 100,000	FY 1974-75
250,000	FY 1975-76
500,000	FY 1976-77
750,000	FY 1977-78
1,000,000	FY 1978-79

The Five Years Ahead-

Summary Of The Plan

CHAPTER V

THE FIVE YEARS AHEAD: SUMMARY OF THE PLAN

The challenge presented to the Division of Mental Retardation, other human service agencies and the citizens of Tennessee is dignity for every mentally retarded individual. The strategies to meet that challenge have been decided. The concentration will be on changing the traditional institutional system and on developing living and training situations in the community environment to meet the needs of most mentally retarded persons.

The plan is realistic. It calls for incremental increases and program improvements at the Developmental Centers to upgrade services to meet AC/FMR accreditation standards. A per diem cost per resident of thirty to thirty-five dollars is not exorbitant for specialized institutional care. The costs at the Developmental Centers will rise as each seeks improvements necessary for accreditation. Then costs should stabilize, inflation not included, since the emphasis on expansion will be directed toward community services. By FY 1978-79, the Developmental Centers will have completed renovation and reprogramming goals and will have reached the following goals in bed capacities:

Arlington Developmental Center	640
Clover Bottom Developmental Center	750
Greene Valley Developmental Center	750

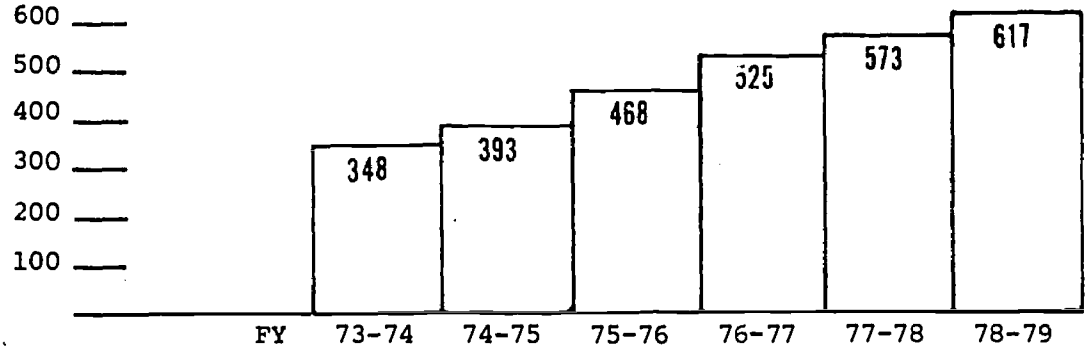
The point in favor of community training and living for mentally retarded persons is the significant reduction in costs as compared to the operation of institutions. The five year plan would provide community day training services

to 2,463 mentally retarded persons and community residential placements for almost 1,400 persons. These community services would represent a total investment from all revenue sources in FY 1978-79 of approximately fourteen million dollars. If Tennessee is committed to facing the challenge of appropriate services for her mentally retarded citizens, the investment is not unreasonable and the rewards in terms of human dignity and happiness for many formerly neglected citizens will justify the efforts.

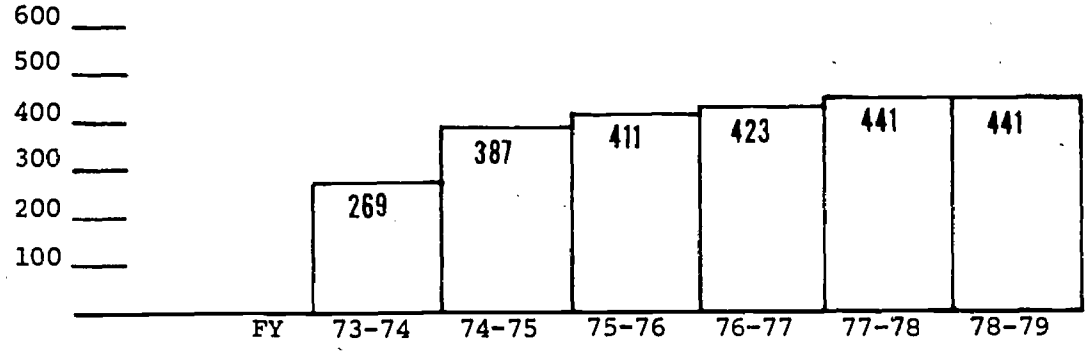
Conclusion. This plan is intentionally presented in draft version and has been designated as such to stimulate and encourage input, criticism and suggestions from anyone or any organization concerned with the well being of mentally retarded persons. Furthermore, the plan will need continuous revision to reflect changing needs and philosphies concerning mental retardation. This report does not purport to meet every facet of service needs of mentally retarded persons. Other detailed studies will be forthcoming concerning action for multiply-handicapped mentally retarded individuals, such as the deaf retarded, blind retarded, deaf and blind retarded, emotionally disturbed retarded, severe physically handicapped retarded and the mentally retarded offender.

This is not an end, it is a beginning. If the plan is relegated to collecting dust on the bookshelf, it will become little more than an academic exercise. Only by action can we aid in helping mentally retarded persons achieve the dignity of life to which they are entitled.

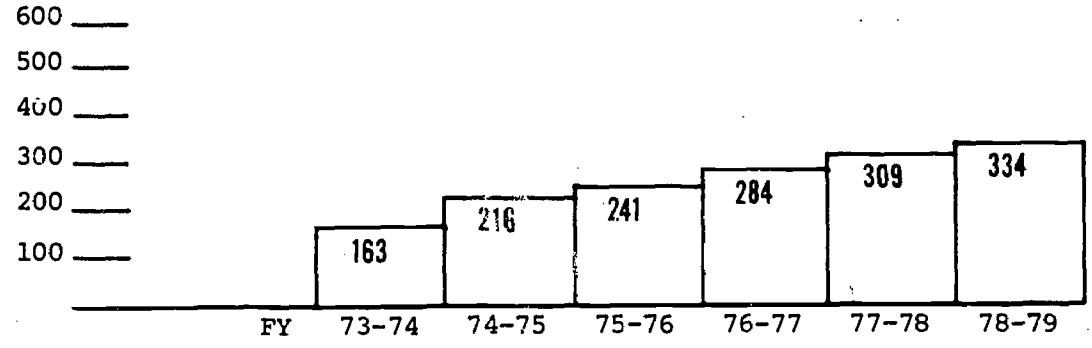
PROJECTED GROWTH
TOTAL NUMBER OF ADULT ACTIVITY CLIENTS
FY 1973-74--FY 1978-79



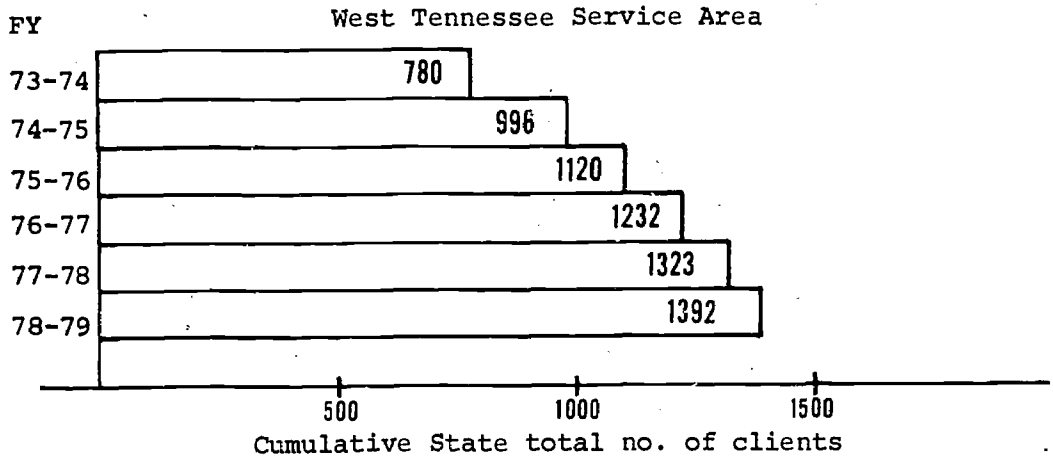
East Tennessee Service Area



Middle Tennessee Service Area



West Tennessee Service Area



Cumulative State total no. of clients

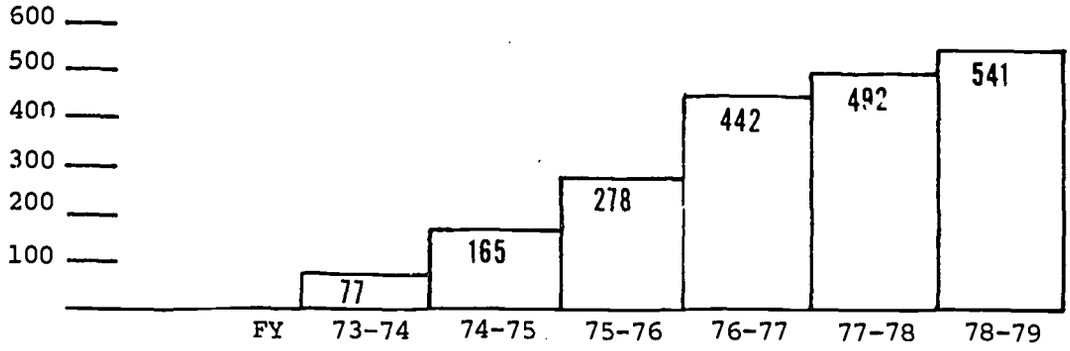
TABLE II

PROJECTED GROWTH IN TOTAL NUMBER OF ADULT ACTIVITY CLIENTS
FY 1973 - 74 through FY 1978 - 79

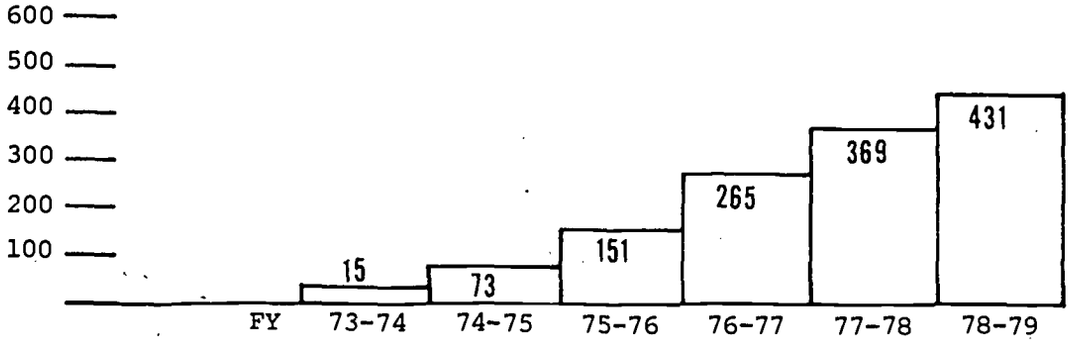
CUMULATIVE TOTAL NUMBER OF CLIENTS

SERVICE AREA:	EAST	MIDDLE	WEST	Annual Increase Over Previous Year	CUMULATIVE STATE TOTAL
73-74	348	269	163		780
74-75	393 (45 increase)	387 (118 increase)	216 (53 increase)	216	996
75-76	468 (75 increase)	411 (24 increase)	241 (25 increase)	124	1,120
76-77	525 (57 increase)	423 (12 increase)	284 (43 increase)	112	1,232
77-78	573 (48 increase)	441 (18 increase)	309 (25 increase)	91	1,323
78-79	617 (44 increase)	441 (0 increase)	334 (25 increase)	69	1,392

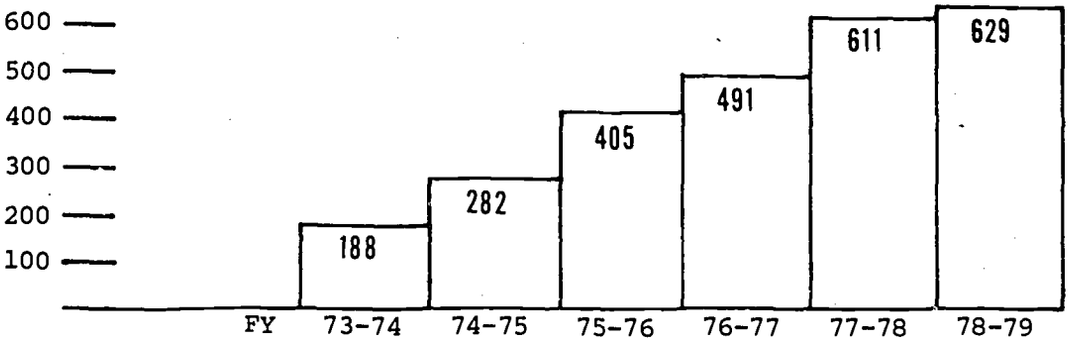
PROJECTED GROWTH
TOTAL NUMBER OF SHELTERED WORKSHOP CLIENTS
FY 1973-74--FY 1978-79



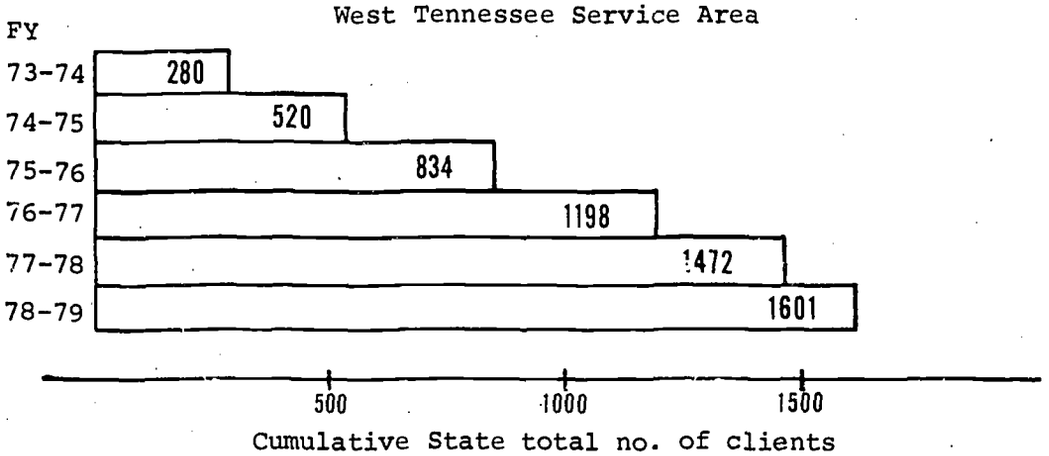
East Tennessee Service Area



Middle Tennessee Service Area



West Tennessee Service Area



Cumulative State total no. of clients

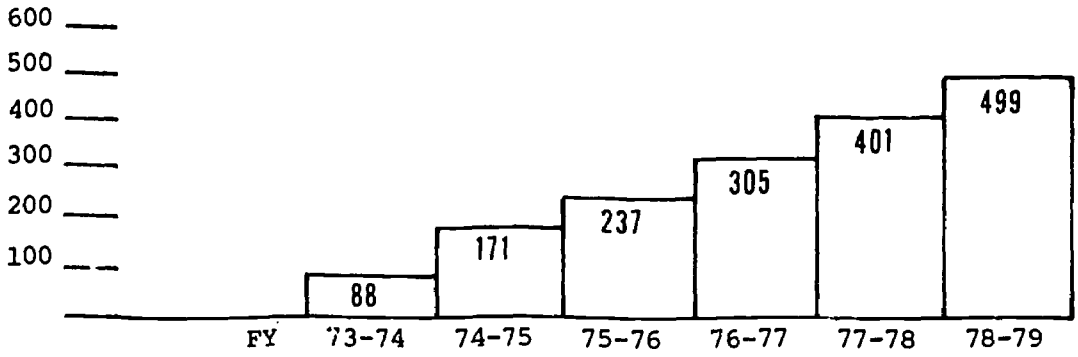
TABLE III

PROJECTED GROWTH IN TOTAL NUMBER OF SHELTERED WORKSHOP CLIENTS
FY 1973 - 74 through FY 1978 - 79

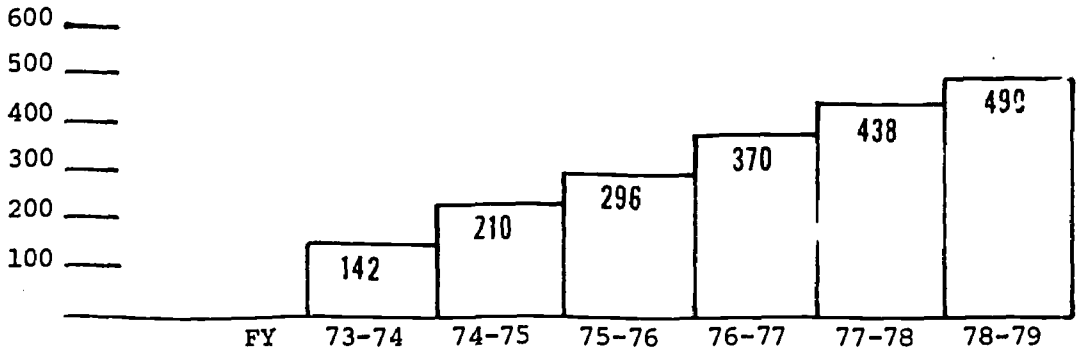
CUMULATIVE TOTAL NUMBER OF CLIENTS

SERVICE AREA:	EAST	MIDDLE	WEST	Annual Increase Over Previous Year	CUMULATIVE STATE TOTAL
73-74	77	15	188		280
74-75	165 (88 increase)	73 (58 increase)	282 (94 increase)	240	520
75-76	278 (113 increase)	151 (78 increase)	405 (123 increase)	314	834
76-77	442 (164 increase)	265 (114 increase)	491 (86 increase)	364	1,198
77-78	492 (50 increase)	369 (104 increase)	611 (120 increase)	274	1,472
78-79	541 (49 increase)	431 (62 increase)	629 (18 increase)	129	1,601

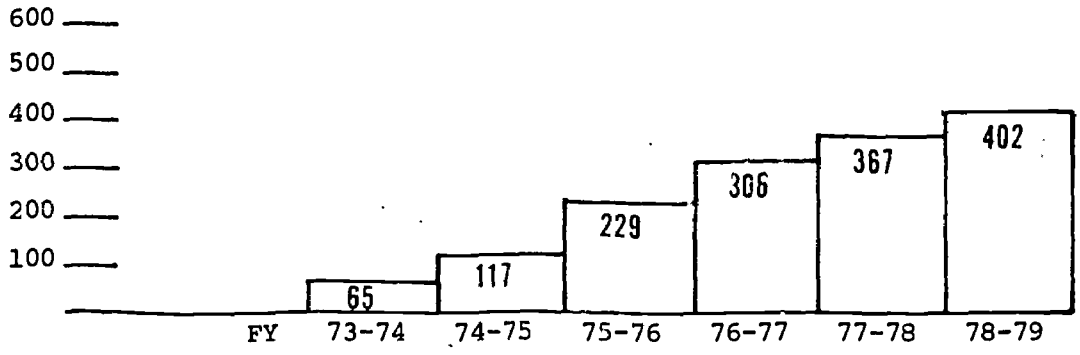
PROJECTED GROWTH
TOTAL NUMBER OF COMMUNITY RESIDENTIAL PLACEMENTS
FY 1973-74--FY 1978-79



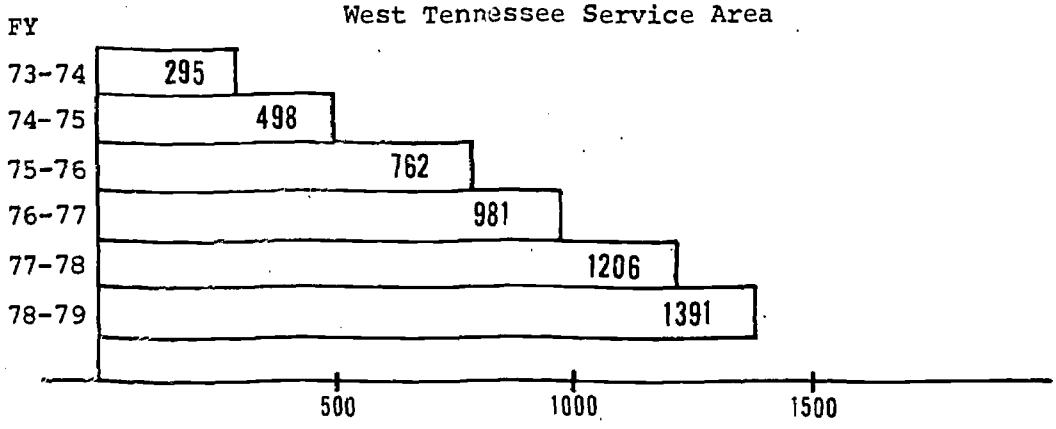
East Tennessee Service Area



Middle Tennessee Service Area



West Tennessee Service Area



Cumulative State total no. of clients

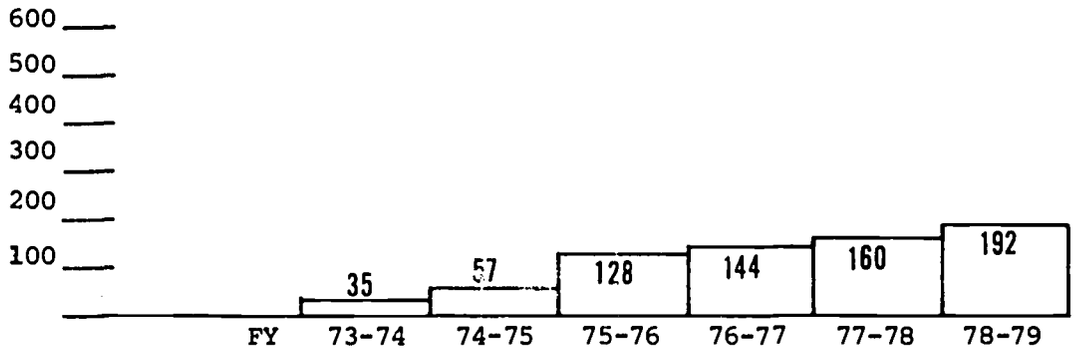
TABLE IV

PROJECTED GROWTH IN TOTAL NUMBER OF COMMUNITY RESIDENTIAL PLACEMENTS
FY 1973 - 74 through FY 1978 - 79

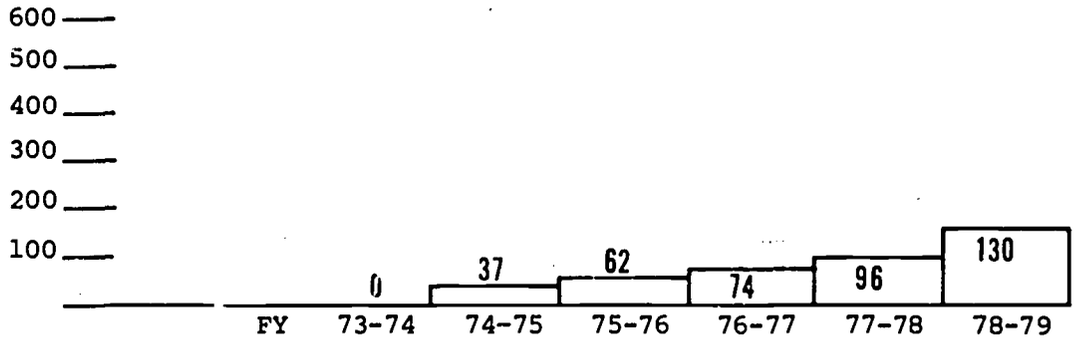
CUMULATIVE TOTAL NUMBER OF CLIENTS

SERVICE AREA:	EAST	MIDDLE	WEST	Annual Increase Over Previous Year	CUMULATIVE STATE TOTAL
73-74	88	142	65		295
74-75	171 (83 increase)	210 (68 increase)	117 (52 increase)	203	498
75-76	237 (66 increase)	296 (86 increase)	229 (112 increase)	264	762
76-77	305 (68 increase)	370 (74 increase)	306 (77 increase)	219	981
77-78	401 (96 increase)	438 (68 increase)	367 (61 increase)	225	1,206
78-79	499 (98 increase)	490 (52 increase)	402 (35 increase)	185	1,391

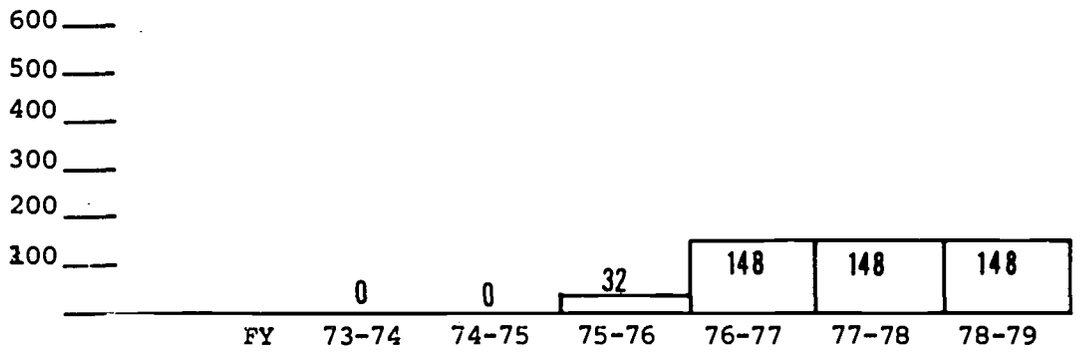
PROJECTED GROWTH
TOTAL NUMBER OF PRESCHOOL TRAINING CLIENTS
FY 1973-74--FY 1978-79



East Tennessee Service Area



Middle Tennessee Service Area



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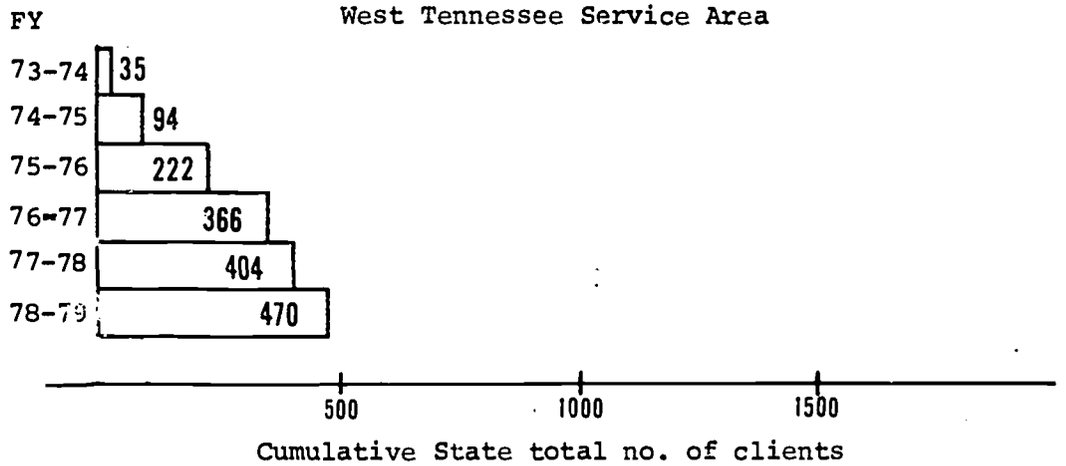


Cumulative State total no. of clients

TABLE V

PROJECTED GROWTH IN TOTAL NUMBER OF PRESCHOOL TRAINING CLIENTS*
FY 1973 - 74 through FY 1978 - 79

CUMULATIVE TOTAL NUMBER OF CLIENTS

SERVICE AREA:	EAST	MIDDLE	WEST	Annual Increase Over Previous Year	CUMULATIVE STATE TOTAL
73-74	35				35
74-75	57 (22 increase)	37 (37 increase)	(0 increase)	59	94
75-76	128 (71 increase)	62 (25 increase)	32 (12 increase)	128	222
76-77	144 (16 increase)	74 (12 increase)	148 (116 increase)	144	366
77-78	160 (16 increase)	96 (22 increase)	148	38	404
78-79	192 (32 increase)	130 (34 increase)	148	66	470

*Current Title IV-A, Social Security Act. Day Training Centers not included.

TABLE VI

TOTAL PROJECTED COSTS FOR COMMUNITY PROGRAMS

FY 1973 - 74 through FY 1978 - 79

AREA OF STATE		FY 1973 - 74	FY 1974 - 75	FY 1975 - 76	FY 1976 - 77	FY 1977 - 78	FY 1978 - 79
EAST	continuation		$1,480,195	$2,138,753	$3,132,401	$3,992,299	$4,963,472
	new programs		518,640	788,725	598,720	646,460	725,175
	sub-total	$1,389,360	1,998,835	2,927,478	3,731,121	4,638,759	5,688,647
MIDDLE	continuation		1,240,665	2,042,046	2,726,650	3,373,924	4,135,222
	new programs		667,790	506,225	426,550	490,770	417,500
	sub-total	1,159,500	1,908,455	2,548,271	3,153,200	3,864,694	4,552,722
WEST	continuation		776,114	1,224,244	1,876,560	3,017,449	3,659,848
	new programs		368,040	529,550	943,485	402,970	253,525
	sub-total	725,340	1,144,154	1,753,794	2,820,045	3,420,419	3,913,373
STATE TOTAL	continuation		3,496,974	5,405,043	7,735,611	10,383,672	12,758,542
	new programs		1,554,470	1,824,500	1,959,755	1,540,200	1,396,200
	GRAND TOTAL	$3,274,200	$5,051,444	$7,229,543	$9,695,366	$11,923,872	$14,154,742

APPENDIX I

NUMBER OF MENTALLY RETARDED PERSONS IN TENNESSEE:

A STATISTICAL ESTIMATE

It is extremely difficult for the community or the Division of Mental Retardation to plan concretely for provisions to meet all the needs of all mentally retarded persons. One major bulwark to planning efforts lies in the deficit of precise and reliable data about the population to be served.

Projections of incidence of mental retardation among the general population are "ball-park" guesses, although some studies have supplied percentage estimates based on sampling survey techniques. Until programs for the developmentally disabled become more widespread and until diagnostic and evaluation procedures reach a higher level of sophistication and application, statistical estimates to define and describe the mentally retarded population of our state become the most valid measure. Authorities agree that statistical estimates tend to underestimate the true number of mentally retarded persons, especially in the higher functioning categories.

Incidence of mental retardation is generally higher in extremely rural pockets of poverty and in city ghettos. Factors such as these were not included in the exhibits presented in Appendix I.

The following statistical estimates are based on the Hypothetical Community Study, by Donald J. Stedman, assuming a 3% incidence rate of mental retardation. Based upon the 1970 census, the age figures stated in the Hypothetical Community Study have been converted to more relevant categories for the purpose of planning in Tennessee.

Estimates of mentally retarded persons age birth to four years are treated separately. These figures have relevance in planning for preschool and early intervention programs. Mentally retarded persons in the category of age four to 21 years are the responsibility of the Department of Education and local educational systems as a result of mandatory education legislation. However, the age range 18 to 21 is defined since many adult programs of the Department of Mental Health involve young adults between these ages. Mentally retarded persons in the age 21 and over category again become the responsibility of the Department of Mental Health for the provision of all types of services.

Estimates are separated into regions, with regions listed by Developmental Center Service Area.

The following tables were utilized in planning for specialized services in each region and were useful in determining eventual placements of programs and facilities. The Developmental Disabilities Services Section of the Division of Mental Retardation has embarked on a federally funded project for the systematic collection of data concerning the developmentally disabled in the state. When complete, the Registry System for the Developmentally Disabled will be continually updated and contain basic individual information on the types, extent and programmatic needs of all persons identified in the system. But until an accurate census of the handicapped is available, statistical estimates remain the only data tool available for planning purposes.

MENTAL RETARDATION POPULATION ESTIMATES

EXHIBIT A
EAST TENNESSEE DEVELOPMENTAL CENTER SERVICE AREA

EXHIBIT B
MIDDLE TENNESSEE DEVELOPMENTAL CENTER SERVICE AREA

EXHIBIT C
WEST TENNESSEE DEVELOPMENTAL CENTER SERVICE AREA

EXHIBIT A

MENTAL RETARDATION POPULATION ESTIMATES

EAST TENNESSEE DEVELOPMENTAL CENTER SERVICE AREA

County	Total Population (1970)	Total M.R. Population	Summary - By Degree: Mild	Moderate	Severe	Summary - By Age Grouping: Pre-School	School Age	Young Adults	Adults
First Tennessee Developmental Region									
Carter	43259	1298	1082	174	42	89	371	73	765
Greene	47630	1428	1192	190	46	98	409	80	841
Hancock	6719	202	168	27	7	14	58	11	119
Hawkins	33726	1012	844	136	32	69	290	57	596
Johnson	11569	347	290	46	11	24	99	19	205
Sullivan	127329	3820	3188	508	124	263	1093	212	2252
Unicoi	15254	459	382	62	15	32	133	26	270
Washington	73924	2217	1852	295	70	153	634	124	1306
TOTAL	359410	10783	8998	1438	347	742	3085	602	6354
East Tennessee Developmental Region									
Anderson	60300	1810	1510	241	59	125	518	100	1067
Blount	63744	1912	1595	255	62	132	547	106	1127
Campbell	26045	780	650	104	26	54	224	43	459
Calfhorne	19420	583	487	77	19	40	168	32	343
Cocke	25283	759	632	102	25	52	217	42	447
Grainger	13948	419	349	56	14	29	120	23	247
Hamblen	38696	1161	968	155	38	81	332	65	683
Jefferson	24940	749	623	101	25	52	213	42	442
Knox	276293	8287	6921	1103	263	567	2374	468	4879
Loudon	24266	729	607	97	25	51	208	40	430
Monroe	23475	704	587	93	24	48	202	39	415
Morgan	13619	409	341	55	13	28	117	23	241
Roane	38881	1166	972	156	38	81	333	65	687
Scott	14762	444	370	59	15	30	127	25	262
Sevier	28241	847	706	113	28	59	242	47	499
Union	9072	271	226	35	10	19	76	16	160
TOTAL	700985	21030	17544	2802	684	1448	6018	1176	12388
Southeast Tennessee Developmental Region									
Bledsoe	7643	228	191	30	7	15	66	13	134
Bradley	50686	1522	1269	204	49	105	435	85	897
Grundy	10631	319	265	43	11	22	91	18	188
Hamilton	254236	7625	6367	1015	243	526	2182	424	4493
Marion	20577	617	514	83	20	42	177	35	363
McMinn	35462	1064	888	142	34	73	305	60	626
Meigs	5219	157	132	20	5	10	45	8	94
Polk	11669	348	291	46	11	24	99	20	205
Rhea	17202	516	430	69	17	36	148	29	303
Sequatchie	6331	190	159	25	6	13	54	10	113
TOTAL	419650	12586	10506	1677	403	866	3602	702	7416
TOTAL EAST TENNESSEE	1480051	44399	37048	5917	1434	3056	12705	2480	26158

Further Breakdown - By Degree and Age

Mild				Moderate				Severe			
Pre-School	School Age	Young Adults	Adults	Pre-School	School Age	Young Adults	Adults	Pre-School	School Age	Young Adults	Adults
74	309	61	638	12	50	10	102	3	12	2	25
82	342	66	702	13	54	11	112	3	13	3	27
12	48	9	99	2	8	2	15		2		5
58	242	47	497	9	39	8	80	2	9	2	19
20	83	15	172	3	13	3	27	1	3	1	6
217	915	179	1877	38	143	28	299	8	35	5	76
27	109	22	224	4	18	3	37	1	4	1	9
128	530	104	1090	20	84	16	175	5	20	4	41
618	2578	503	5299	101	409	81	847	23	98	18	208
104	432	84	890	17	69	13	142	4	17	3	35
110	456	89	940	18	73	14	150	4	18	3	37
45	187	36	382	7	30	6	61	2	7	1	16
34	141	27	285	5	22	4	46	1	5	1	12
43	181	35	373	7	29	6	60	2	7	1	15
24	100	19	206	4	16	3	33	1	4	1	8
67	277	54	570	11	44	9	91	3	11	2	22
43	177	35	368	7	29	6	59	2	7	1	15
476	1987	390	4068	76	312	63	652	15	75	15	158
42	173	34	358	7	28	5	57	2	7	1	15
40	169	33	346	6	27	5	55	2	7	1	14
23	97	19	202	4	16	3	32	1	4	1	7
67	277	54	574	11	45	9	91	3	11	2	22
25	106	21	218	4	17	3	35	1	4	1	9
49	202	39	416	8	32	6	67	2	8	2	16
16	69	13	134	2	10	2	21	1	3	1	5
1208	5024	982	10330	194	799	157	1652	46	195	37	406
13	55	11	112	2	9	2	17		2		5
87	363	71	748	15	58	11	120	3	14	3	29
18	76	15	156	3	12	2	26	1	3	1	6
440	1825	354	3748	68	288	60	599	18	69	10	146
35	147	29	303	6	24	5	48	1	6	1	12
61	254	50	523	10	41	8	83	2	10	2	20
9	38	7	78	1	6	1	12		1		4
20	83	16	172	3	13	3	27	1	3	1	6
30	123	24	253	5	20	4	40	1	5	1	10
11	45	9	94	2	7	1	15		2		4
724	3009	586	6187	115	478	97	987	27	115	19	242
2550	10611	2071	21816	410	1686	335	3486	96	408	74	856

EXHIBIT B

MENTAL RETARDATION POPULATION ESTIMATES

MIDDLE TENNESSEE DEVELOPMENTAL CENTER SERVICE AREA

County	Total Population (1970)	Total M.R. Population	Summary by degree			Summary by age groups				Further Breakdown - By Degree and Age											
										Mild				Moderate				Severe			
			Mild	Moderate	Severe	Pre-School	School Age	Young Adults	Adults	Pre-School	School Age	Young Adults	Adults	Pre-School	School Age	Young Adults	Adults	Pre-School	School Age	Young Adults	Adults
Upper Cumberland Developmental Region																					
Cannon	8467	254	211	34	9	17	73	14	150	14	60	11	126	2	10	2	20	1	3	1	4
Clay	6624	198	165	26	7	13	57	11	117	11	48	9	97	2	7	2	15		2		5
Cumberland	20733	622	518	84	20	43	178	35	366	36	148	29	305	6	24	5	49	1	6	1	12
DeKalb	11151	334	278	45	11	23	96	19	196	19	80	16	163	3	13	2	27	1	3	1	6
Fentress	12593	379	316	50	13	26	109	21	223	22	90	18	186	3	15	3	29	1	4		8
Jackson	8141	243	204	31	8	16	69	14	144	13	58	12	121	2	9	2	18	1	2		5
Macon	12315	369	309	48	12	25	106	21	217	21	88	17	183	3	14	3	28	1	4	1	6
Overton	14866	447	373	59	15	31	128	25	263	26	107	21	219	4	17	3	35	1	4	1	9
Pickett	3774	114	95	16	3	8	33	7	66	7	27	6	55	1	5	1	9		1		2
Putnam	35487	1064	888	142	34	73	304	59	628	61	254	50	523	10	41	7	84	2	9	2	21
Smith	12509	375	313	49	13	26	107	21	221	22	89	17	185	3	14	3	29	1	4	1	7
Van Buren	3758	114	96	15	3	8	33	6	67	7	28	5	56	1	4	1	9		1		2
Warren	26972	809	676	107	26	56	231	45	477	46	193	38	399	8	30	6	63	2	8	1	15
White	16355	491	409	65	17	34	140	28	289	28	117	23	241	5	18	4	38	1	5	1	10
TOTAL	193745	5813	4851	771	191	399	1664	326	3424	333	1387	272	2859	53	221	44	452	13	56	10	112
Mid-Cumberland Developmental Region																					
Cheatham	13190	399	329	53	13	27	113	22	233	23	94	18	194	4	15	3	31		4	1	8
Davidson	447877	13437	11211	1792	433	925	3845	750	7917	772	3208	626	6605	123	513	100	1057	30	124	24	255
Dickson	21977	659	551	87	21	45	189	37	388	38	159	31	324	6	25	5	51	1	6	1	13
Houston	5845	175	146	24	5	12	50	10	103	10	42	8	86	2	7	2	13		1		4
Humphreys	13560	406	339	54	13	28	116	23	239	23	97	19	200	4	15	3	32	1	4	1	7
Montgomery	62721	1883	1570	252	61	130	537	105	1109	108	449	88	925	18	72	14	148	4	18	3	36
Robertson	20102	603	728	117	28	60	250	49	514	59	200	40	422	8	33	7	69	2	8	2	16
Rutherford	59428	1782	1486	237	59	123	510	99	1050	103	425	83	875	16	68	13	140	4	17	3	35
Stewart	7319	219	182	29	8	15	63	12	129	12	53	10	107	2	8	2	17	1	2		5
Sumner	56106	1682	1404	224	54	116	481	94	991	97	401	79	827	15	63	12	132	4	15	3	32
Trousdale	5155	155	130	20	5	11	44	9	91	9	37	7	77	2	6	1	11		1	1	3
Williamson	34330	1031	861	137	33	71	295	57	608	59	246	48	508	10	39	7	81	2	10	2	19
Wilson	36999	1110	925	149	36	76	317	62	655	63	264	52	546	10	43	8	89	3	16	2	21
TOTAL	793618	23807	19862	3176	769	1639	6812	1329	14027	1367	5683	1109	11703	220	909	177	1879	52	220	43	454
South Central Developmental Region																					
Bedford	25039	751	627	101	23	52	215	42	442	44	180	35	369	7	28	6	60	1	7	1	14
Coffee	32572	977	815	131	31	67	280	55	575	56	233	46	480	9	38	7	77	2	9	2	18
Franklin	27244	818	682	109	27	56	234	45	483	47	195	37	403	8	31	6	64	1	8	2	16
Giles	22138	664	554	90	20	46	190	37	391	39	158	31	326	6	26	5	53	1	6	1	12
Hickman	12096	363	304	48	11	25	104	20	214	21	87	16	180	3	14	3	28	1	3	1	6
Lawrence	29097	873	728	117	28	60	250	49	514	50	209	40	429	8	33	7	69	2	8	2	16
Lewis	6761	204	169	27	8	14	58	11	121	11	48	10	100	2	8	1	16	1	2		5
Lincoln	24318	730	609	98	23	50	209	41	430	41	174	35	359	7	28	5	58	2	7	1	13
Marshall	17319	520	434	69	17	36	149	29	306	30	124	24	256	5	20	4	40	1	5	1	10
Maury	44028	1321	1102	177	42	91	378	74	778	76	315	62	649	12	51	10	104	3	12	2	25
Moore	3568	107	90	14	3	7	31	6	63	6	26	5	53	1	4	1	8		1		2
Perry	5238	157	132	20	5	11	45	9	92	9	38	8	77	1	6	1	12	1	1		3
Wayne	12365	371	310	49	12	25	106	21	219	21	89	17	183	3	14	3	29	1	3	1	7
TOTAL	261783	7856	6556	1050	250	540	2249	439	4628	451	1876	366	3863	72	301	59	618	17	72	14	147
TOTAL MIDDLE TENNESSEE	1249146	37476	31269	4997	1210	2578	10725	2094	22079	2151	8946	1747	18425	345	1431	280	2941	82	348	67	713

EXHIBIT C

MENTAL RETARDATION POPULATION ESTIMATES

WEST TENNESSEE DEVELOPMENTAL CENTER SERVICE AREA

County	Total Population (1970)	Summary by degree: Total M.R. Population	Mild	Moderate	Severe	Summary by age groups: Pre-School	School Age	Young Adults	Adults	Further Breakdown – By Degree and Age: Mild: Pre-School	School Age	Young Adults	Adults	Moderate: Pre-School	School Age	Young Adults	Adults	Severe: Pre-School	School Age	Young Adults	Adults
Northwest Developmental Region																					
Benton	12126	364	304	48	12	25	104	20	215	21	87	16	180	3	14	3	28	1	3	1	7
Carroll	25741	773	645	103	25	53	221	43	456	44	185	36	380	7	29	6	61	2	7	1	15
Crockett	14402	433	360	58	15	30	124	24	255	25	103	20	212	4	17	3	34	1	4	1	9
Dyer	30427	912	761	122	29	63	261	51	537	53	218	42	448	8	35	7	72	2	8	2	17
Gibson	47871	1433	1197	190	46	96	410	81	846	82	342	67	706	11	54	11	114	3	14	3	26
Henry	23749	712	595	94	23	49	204	40	419	41	170	34	350	7	27	5	55	1	7	1	14
Lake	7896	236	198	31	7	16	68	13	139	13	57	11	117	2	9	2	18	1	2		4
Obion	29936	898	749	120	29	62	257	50	529	52	215	41	441	8	34	7	71	2	8	2	17
Weakley	28827	865	722	115	28	60	248	48	509	50	207	40	425	8	33	6	68	2	8	2	16
TOTAL	220975	6626	5531	881	214	454	1897	370	3905	381	1584	307	3259	58	252	50	521	15	61	13	125
Southwest Developmental Region																					
Chester	9927	298	250	39	9	21	86	16	175	17	72	14	147	3	11	2	23	1	3		5
Decatur	9457	284	237	38	9	20	82	15	167	16	68	13	140	3	11	2	22	1	3		5
Hardeman	22435	673	562	90	21	46	192	38	397	38	160	32	331	6	26	5	53	1	6	1	13
Hardin	18212	545	454	73	18	38	156	30	321	32	130	25	267	5	21	4	43	1	5	1	11
Haywood	19596	589	491	79	19	40	167	33	349	34	140	27	290	5	22	5	47	1	5	1	12
Henderson	17291	519	433	69	17	36	149	29	305	30	124	24	255	5	20	4	40	1	5	1	10
Madison	65727	1973	1643	265	65	136	564	111	1162	114	469	92	968	18	76	15	156	4	19	4	38
McNairy	18369	552	460	74	18	38	158	31	325	32	132	26	270	5	21	4	44	1	5	1	11
TOTAL	181014	5433	4530	727	176	375	1554	303	3201	314	1295	253	2668	50	208	41	428	11	51	9	105
Memphis Delta Developmental Region																					
Fayette	22692	681	569	91	21	47	195	38	401	39	163	32	335	6	26	5	54	2	6	1	12
Lauderdale	20271	608	507	81	20	42	174	34	358	35	145	28	299	6	23	5	47	1	6	1	12
Shelby	722014	21661	18074	2888	699	1491	6198	1219	12762	1245	5171	1010	10649	198	827	161	1702	48	200	39	412
Tipton	28001	840	701	111	28	58	240	47	495	48	200	39	414	8	32	6	65	2	8	2	16
TOTAL	792978	23790	19851	3171	768	1638	6807	1329	14016	1367	5679	1109	11696	218	908	177	1868	53	220	43	452
TOTAL WEST TENNESSEE	1194967	35849	29912	4779	1158	2467	10258	2002	21122	2062	8559	1669	17623	326	1368	268	2817	79	332	65	682

APPENDIX II

DECLARATION OF GENERAL AND SPECIAL RIGHTS
OF THE MENTALLY RETARDED

The State of Tennessee adopts as a matter of public policy toward its mentally retarded citizens the declaration of general and special rights of the mentally retarded as adopted by the International League of Societies for the Mentally Handicapped, which declaration reads as follows:

ARTICLE I. The mentally retarded person has the same basic rights as other citizens of the same country and same age.

ARTICLE II. The mentally retarded person has a right to proper medical care and physical restoration and to such education, training, habilitation and guidance as will enable him to develop his ability and potential to the fullest possible extent, no matter how severe his degree of disability. No mentally handicapped person should be deprived of such services by reason of the costs involved.

ARTICLE III. The mentally retarded person has a right to economic security and to a decent standard of living. He has a right to productive work or to other meaningful occupation.

ARTICLE IV. The mentally retarded person has a right to live with his own family or with foster parents; to participate in all aspects of community life, and to be provided with appropriate leisure time activities. If care in an institution becomes necessary it should be in surroundings and under circumstances as close to normal living as possible.

ARTICLE V. The mentally retarded person has a right to a qualified guardian when this is required to protect his personal well-being and interest. No person rendering direct services to the mentally retarded should also serve as his guardian.

ARTICLE VI. The mentally retarded person has a right to protection from exploitation, abuse and degrading treatment. If accused, he has a right to a fair trial with full recognition being given to his degree of responsibility.

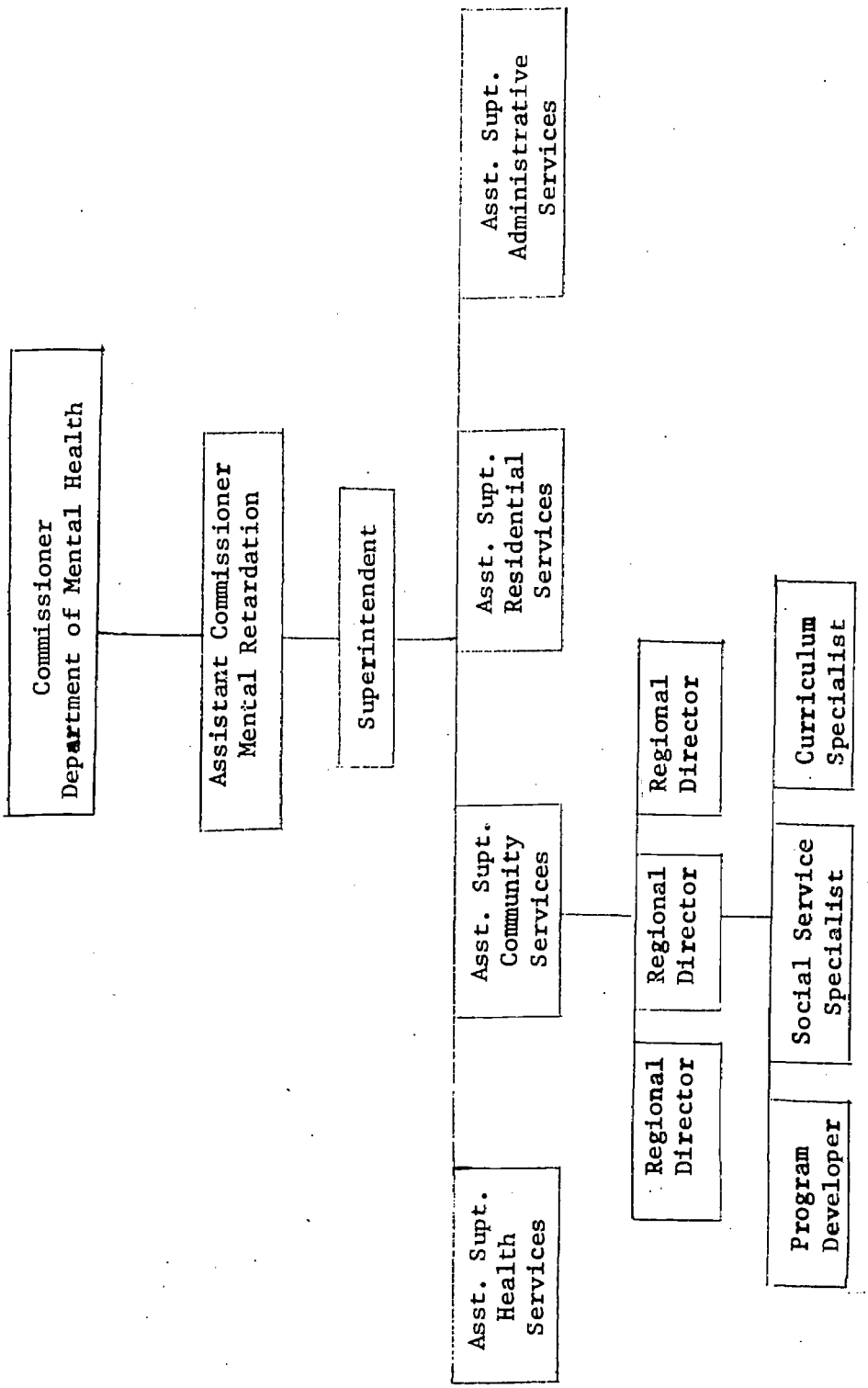
ARTICLE VII. Some mentally retarded persons may be unable, due to the severity of their handicap, to exercise for themselves all of their rights in a meaningful way. For others, modification of some or all of these rights is appropriate. The procedure used for

modification or denial of rights must contain proper legal safeguards against every form of abuse, must be based on an evaluation of the social capability of the mentally retarded person by qualified experts and must be subject to periodic review and to the right of appeal to higher authorities.

(Excerpt from Chapter 289, Public Acts of 1971, State of Tennessee.)

APPENDIX III

ORGANIZATIONAL CHART FOR
DELIVERY OF COMMUNITY
SERVICES



APPENDIX IV

DIAGNOSTIC AND EVALUATION SERVICES

Diagnostic services include but are not limited to the educational, medical, psychological and social aspects of the individual which identify the presence of mental retardation as well as other related conditions. Diagnostic services examine the causes, complications, and consequences of the problem.

Evaluation can be defined as the application of techniques for the systematic appraisal of physical, mental, social, economic, and intellectual resources of an individual and his family for the purpose of devising an individualized program of action to be followed by periodic reappraisal as appropriate. Evaluation determines the extent to which the presenting problem limits, or can be expected to limit, the individual's daily living and working activities and will be expected to be removed, corrected, or minimized by specific intervention services.

Diagnostic and evaluation services are not a once-in-a-lifetime experience. These services should be regarded as on-going, recurring tools upon which comparisons and progress can be noted and changes in service recommended as the individual's needs also change.

ADULT ACTIVITY CENTERS

Adult activity centers in Tennessee were designed to fill a tremendous gap in services for mentally retarded adults.

The majority of mentally retarded adults have not had benefit of special education programs. For most of these adults there have been only two avenues open to them: the state institution and staying home and being cared for by their families. In many instances, parents have cared for their mentally retarded sons or daughters for forty or more years with little if any respite.

Adult activity programs stress activities which provide opportunities to the clients to acquire skills which will enhance their participation in family, community, and economic life. Adult activity centers also provide services for adults who have completed various types of educational programs but are not yet ready for a vocational training or a sheltered workshop program.

Although prevocational skills should be taught and movement from adult activity centers to vocational rehabilitation or sheltered workshops should be available, eventual entry into the work environment should not be stressed as the ultimate goal of every participant in adult training activities. Each individual's goals should be set according to the potentials and capabilities of the client.

SHELTERED WORKSHOPS

Sheltered workshops provide a work situation under closely supervised conditions for mentally retarded adults incapable of immediate success in competitive employment. Work provided for the clients is real and meaningful and clients receive payment for production.

However, a sheltered workshop provides more than a work setting. Each client is evaluated for his vocational potential and adjustment factors and an individualized plan for development is determined. If needed, training is provided in such areas as personal health and appearance, manners, finding employment, keeping a job, getting along with others, budgets and banking.

Sheltered workshops will usually begin as a "spin off" of adult activity centers. After training, many adult activity clients can progress to sheltered workshops. From sheltered workshops, movement into the competitive labor market is often possible. However, sheltered workshops consist of two components:

(1) Long-term sheltered employment is a continuing service for individuals who have adjusted to the learning and practice of work but are unable to sustain the demands of competitive employment. The sheltered workshop provides paid employment on a sustained basis with primary emphasis on productive work for remuneration.

(2) Transititonal employment must be available for those capable of moving on to competitive employment. Provision should be made for retraining or additional training if the client is unable to perform satisfactorily when placed in a competitive job situation.

Because of the handicaps of clients, sheltered workshops may not always be self-supporting, yet revenues from contract work and product sales will assist in relieving the cost burden that must be borne from public sources.

COMMUNITY RESIDENTIAL FACILITIES

Community residential facilities in Tennessee are defined as those residential facilities, located off the grounds of the Developmental Centers, which provide care and training for mentally retarded individuals of all ages and all functioning levels, in an appropriate setting. These facilities take on a variety of settings and sizes.

Variety is necessary and encouraged as long as the program offers quality services in a homelike setting. In some cases, the resident may need close supervision at all times. In this situation, only a very few could be served in the same facility. A facility of this type would necessarily be small because of the degree of supervision provided by the house parents.

Some community residential facilities which primarily serve adults and/or higher functioning residents may have a larger population than those serving the more severely retarded or those with multiple handicaps. The reason for this is that the higher functioning resident can take care of his basic needs and often needs little more than "shadow" supervision. The goal of this type residence is to move the residents into independent living situations such as a private apartment or boarding home.

Tennessee is presently involved in a project to develop scales which will allow objective comparisons of the effectiveness and efficiency of various social skills of retarded adults. The purpose of the project is divided into three primary components.

1. The first component of the project is to develop scales to analyze appropriate social skills for community living of adult retarded people.

2. The second component of the project is to further specify the environmental levels of residences. These levels include: (a) a Level I intensive training unit or nursing home environment; (b) a Level II group

home which operates somewhat like a family unit; (c) a Level III group home, boarding house or halfway house; (d) a Level IV semi-independent apartment arrangement; and (e) a Level V independent apartment or home setting.

3. The third component of the project is to validate the scales and to relate them to various environmental levels of residences for mentally retarded adults.

The development of community residential programs for mentally retarded individuals as alternatives to institutional care has become an economic and humanitarian necessity. The State of Tennessee has accordingly begun to develop a network of prototype community residential programs such as halfway houses, group homes, nursing homes, foster homes, and supervised apartments.

The size of community residential programs is a very important factor. Although community residential programs are much more desirable than institutions, it is also possible to provide little more than warehousing in the community. Adult community residential programs should not involve more than twelve (12) residents within the same structure. Community residential programs for children should focus on small family units with a maximum of six (6) children and preferably four (4).

Homelike atmospheres are always encouraged in community residential facilities. The residences are to be as much like and as little different as the average home on the average street. A community residential program will be considered deficient if residents are not afforded the opportunity to become involved in neighborhood and home activities.

In no case should a community residential facility be established where the residents do not have access to daytime activities. Such activities might include but are not limited to day training centers, adult activity centers, sheltered workshops, competitive or self-employment.

Community residential facilities are generally operated by local,

non-profit boards who contract for services with the Tennessee Department of Mental Health. The local boards in turn hire house parents and any other supportive staff who may be necessary. Such agencies have allowed the Developmental Centers to reduce their population somewhat. Community residential facilities will be the vehicle by which our presently overcrowded Developmental Centers and long waiting lists will be reduced and brought to a manageable level.

PRESCHOOL DAY TRAINING

The programs of preschool day training centers are designed to serve those retarded and/or developmentally disabled children who have substantial mental or mental and physical handicaps. These programs serve children who are under 4 years of age.

By the nature of the clients served, it will be necessary for preschool training programs to have access to specialized services. Such services might include speech therapy, physical therapy, occupational therapy and comprehensive diagnostic and evaluation services.

Preschool day training programs are not designed to serve the general population nor those mentally retarded children who are not substantially handicapped.

The objectives of preschool day training centers might include:

1) To motivate, train and encourage clients toward a more normal way of life.
2) To provide an environment and variety of experiences to further the growth and development of each individual.
3) To provide an opportunity for the client and his family to better understand each other.
4) To provide periods of respite for the family from 24 hour supervision of a substantially handicapped child.
5) To provide family training services to enable families to more appropriately meet the demands of the developmentally disabled child.
6) To offer an alternative to institutional care.